VR A15 (4) 15M 9/60 03

| MARYLAND | STATE | DEPARTMENT | OF | HEALTH |
|----------|-------|------------|----|--------|

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| 1, | PLACE OF DEATH | | | | - 11 | 2. USUAL RESI | DENCE (WI | nere deceasad livad, | If institution: R | asidanca be | ofora admission) |
|---------------|---------------------------------------|-----------------------------------|----------------|-------------------|----------|----------------------|------------------|------------------------|-------------------|-------------|------------------|
| | a. COUNTY | | | | | a. STATE | | b. CO | JNTY | | / |
| | Carroll | | | MARYLA | | Maryla | | | ederic | | V |
| | b. CITY OR TOWN (if | outside corporate limit | s, c. | LENGTH OF STAY I | N 1b | c. CITY OR TO | WN (If outsid | le corporete limits, w | ite RURAL and | give neara | ast town) |
| | Henryton | | 8 | 46 days | | Freder | rick | | 10 | 11-2 | |
| | | AL OR INSTITUTION (in | | | | d. STREET ADD | | | 1.0 | a. | IS RESIDENCE |
| | | State Hos | | | | 19 W. | All S | aints Str | eet | YI | ON A FARM? |
| 3. | NAME OF | First | | Middle | | Last | | ATE Mo | nth | Day | Year |
| | DECEASED (Typa or print) | Fost | | | A | mbush | OI | EATH Dec. | | 5, | 19 61 |
| 5. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 7 8. | DATE OF BIRTH | | 9. AGE (In yes | | YEAR IF U | INDER 24 HRS. |
| 1 | Male | Negro | WIDOWED | DIVORCED | | -25-29 | | 32 yrs. | Months D | ays Ho | ours Min. |
| 10a | . USUAL OCCUPATION | ON (Give kind of work | 10b. KIND (| OF BUSINESS OR IN | DUSTRY | 11. BIRTHPLACE | (County & Sta | ate, or foreign count | y) 12. CITI | ZEN OF WI | HAT COUNTRY? |
| ao | Barten | king life, evan if ratired ler | | ***** | ** | Freder | ick Co | Md. | | U.S. | Α. |
| 13. | FATHER'S NAME | | | | 1 | 4. MOTHER'S MA | IDEN NAME | | | | |
| | Jesse A | mbush | | | | Mary & | . Smit | h | | | |
| 15. | WAS DECEASED EVE | R IN U.S. ARMED FOR | CES? 16. SOC | IAL SECURITY NO. | 17. IN | FORMANT | | Addr | SS | | |
| (Ye | Yes (It | yes give war or dates of se | rvice) | 21 6671 | TO. | | h b . D | - 4-2 4 | | | |
| | | ATH [Entar only ona | Z_1_ | 24-0034 | T.C | ster Am | busn-P | atlent | | LINITEDY | AL BETWEEN |
| | | WAS CAUSED BY: | | | | • 1 | - | | | | AND DEATH |
| | | MMEDIATE CAUSE (a)_ | rar ac | lvanced b | ıı. | cavitar | y pulm | . tbc. | | - | |
| | 00 | DUE TO | | | | | | | | | |
| | Conditions, if any, | which) (b) | | | | | | | | | |
| Ε. | gava rise to immedia | DUIT TO | | | | | | | | 1 | |
| | (a), stating the un | dariying | | | | | | | | | |
| _ | | SIGNIFICANT CONDIT | IONE CONTRIB | ITING TO DEATH B | TOTA TIL | DEL A TED TO THE | PERMINIAL DIS | SEASE CONDITION O | IVENI INI DADT | 1/a\1.10 \ | VAS ALITORSY |
| Ó | PART II. OTHER | SIGNIFICANT CONDIT | IONS CONTRIB | UTING TO DEATH B | UINOI | KELATED TO THE | IEKMINAL DIS | SEASE CONDITION | IVEN IN PAKE | 1(a) 17. V | PERFORMED? |
| CAT | | | | | | | | | | YES | □ NO ⊡ |
| CERTIFICATION | 2Da. ACCIDENT WA OR CONTRIBUTING I | | 2Db. DESCRIBE | HOW INJURY OC | CURED. (| Enter natura of inju | ury in Pert I or | Part II of item 18.) | | | |
| | 20c. TIME OF INJUR | Y Month, Day, Yea | * 1304 INIIII | RY OCCURRED 2D | n DIAC | OF INJURY (Hom | o form ! 20f | (City or town) | (Cour | dv) | (State) |
| MEDICAL | Hour a.m. | 19 | | Not While at work | | , street, office bld | | . (City of lowin) | (600) | 177 | (Siale) |
| | | at (I) (this hospit | al) attended | the deceased f | rom. | ug. 12, | 1959 | to Dec. | 196 | 1. that | (I) (we) last |
| | | advalive on De | | | | | a5:15 | | | | |
| | DO- CICALATURE | X | | | mar | Cam occar o | Operation print | HOM MO GGGG | 0110 011 11 | 10 0010 | 22b. DATE |
| | 228. SIGNATORE | odgars 1 | nimas | nlace | M.D | ATTENDING PHYS. | MED. | OR PHYS. | 1 | 1 | 2-5-61 |
| | 22c. PHYSICIAN'S | | | / | 7711.5 | 22d. ADDRES | 5 | | | | |
| | NAME (Type) | Dr. Edgar | s M. Ma | culans, | Supt | Henr | yton S | tate Hos | Her | ryto | n, Md. |
| 23 | BURIAL, CREMATIC | ON, 236. DATE THER | EOF 23 | . NAME OF CEME | TERY O | CREMATORY | 23d. | LOCATION LAIR | town on sounty | h. | (State) |
| | Burial (Specify) | 12-9-6 | 1 | Fairvie | W | | - | tredire | ch) | 2 | rd. |
| 24 | FUNERAL DIRECTOR | S SIGNATURE | Fre | deprisek- | Md. | 0 2 25 | REC'D BY | REGISTRAR 256. | EGISTRAR'S S | IGNATURE | |
| K | E Pel | Ticks 11 | L24 | wallka | in Z | 16. DA | TE DEC 1 | 3 '61 | O-Thun 1 | House | |
| '= | | | | | | | | | | | |

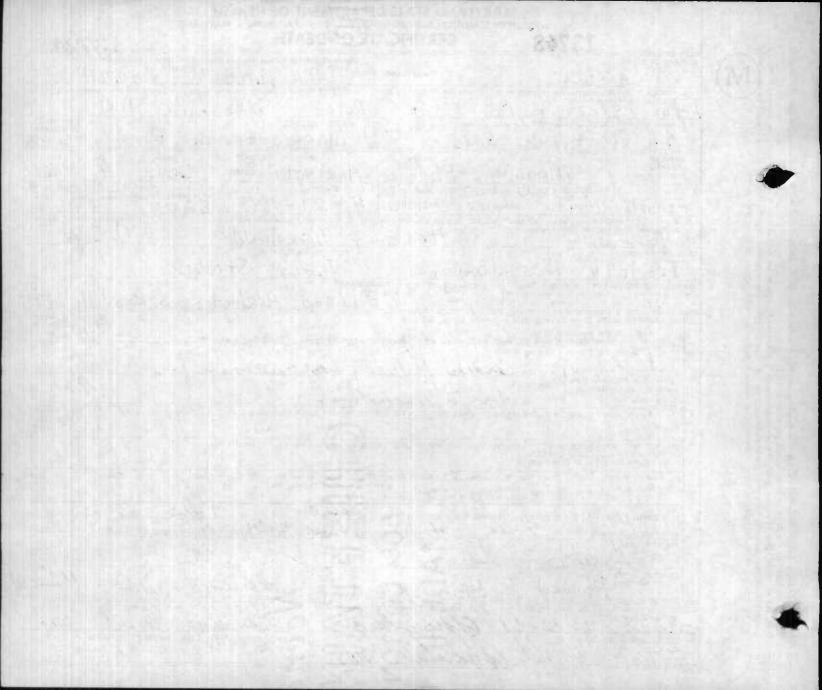
1372 F THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWI The state of the s 2 2 2 .50 49-You have been seen as the seen of the seen ALC: A LONG TO SELECT AND A SELECTION OF THE PARTY OF THE 是是一种对象的问题,大量是一种特殊的一种发生性情况,不是这些人的变形的。这一是一种发现。 *Lifetolushori va" voivals 18-9-81 Zeing C. P. Hadall Land Constitution of the Constitu

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 12710

A ONIO A

| _ | 40110 | | | | 10/24 |
|-----|--|--------------|--|---|---------------------------------------|
| 1 | PLACE OF DEATH | | 2. USUAL RESIDENCE (Where decea | | nce before admission) |
| | O. COUNTY CARROLL | ARYLAND | a. STATE MARY IAM | d b. COUNTY CAN | eroll |
| | b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF S | TAY IN 1b | c. CITY OR TOWN (If butside cor | porote limits, write RURAL and | give nearest town) |
| 6 | RURAL and give pearest town) CRA SYKESVILLE Md Li | fe 1 | XRUPAL SYK | esville. 1 | McI. |
| - | d. NAME OF HOSPITAL (If not in hospital, give street oddress) | | d. STREET ADDRESS | , | e. IS RESIDENCE ON A FARM? |
| | MARRIOTTS VILLE ROAD | | MARRIOTTS | sville RoAd | |
| 3 | DECEASED | Renee | ARRING ton DEAT | TH Dec. | 9, 1961 |
| 5 | SEX 6. COLOR OR RACE . MARRIED NEVER M. | ARRIED B | DATE OF BIRTH | 9. AGE (In years IF UNDER last birthdoy) Months | Doys Hours Min. |
| | 1 Chilly Collins | ORCED | 4-21-1881 | 80 yrs. | |
| 1 | Oa. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINE during most of working life, even if retired) | SS OR INDUST | TRY 11. 8IRTHPLACE (State or foreign | country) 12.CIT | IZEN OF WHAT COUNTRY? |
| L | | ome | MARYIANC | 1 (| 1, S.A. |
| 1. | 3. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | 5 | |
| L | FREGRICK HUSSELDAUGH | | | trover | |
| 1: | S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY | NO. 17. IN | FORMANT | Address | 11 1/1 |
| | No - | E | COWARD HRRI | ngton - SYKe | sville, M. |
| T | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and | (c).] | | J | INTERVAL BETWEEN |
| 1 | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | buc | unoma an | mis . | 1960 |
| | DUE TO | .1 | 1 | | -4- |
| | Conditions, if ony, which) | heline. | . Correspon | in L | 16 |
| | gove rise to immediate DUE TO | To Court | | | 1961 |
| | lying couse lost. | me ho | fair - | | 1701 |
| 1 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO | DEATH BUT I | NOT RELATED TO THE TERMINAL DISE | ASE CONDITION GIVEN IN PA | RT 1(o) 19. WAS AUTOPSY PERFORMED? |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO | | | | YES NO |
| | | RY OCCURRED | . (Enter noture of injury in Port I or I | Part II of item 18.) | |
| 1 | COO., ACCIDENT WAS UNDERLYING COOK OF CONTRIBUTING COUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 1 | 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED | | | City or town) | (County) (Stote) |
| 1 | 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED While Not while at work of twork | fact | tory, street, office bldg., etc.) | | |
| 1 | | 1.0 | 1660 | 9 1010 101 | () Al-24 () 1 |
| | 21. I certify that (I) (this haspital) attended the decea | | 19 19 10 10 1c | | 4, that (I) (we) last |
| | sow the deceosed alive on 7 Pere 19 01, | ond that de | eath occurred at 7.30 Miro | m the couses ond on th | 22b. DATE |
| | ZZZ SIGNATUR | 1133 | ATTENDING MED. | STAFF PHYS. | SIGNED |
| H | 22c. PHYSICIAN'S | N | A.D. PHYS. DIRECTOR 22d. ADDRESS | PHTS | 1.10 |
| | NAME (Type) HOWARD. E. HALL | M.D. | AN | will , mh | , Il Dech |
| 1 | 30. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF | CEMETERY OF | COMMITTERY 231 199 | CATION (City, town, or county) | All (State) A |
| | Burel 12-12-61 Office | intell | de Oly | buckle. Para | ella mil |
| 2 | FUNERAL DIRECTOR'S SIGNATURE _ ADDRESS | 10 | 7 250. RECO. BY REC | DISTRAR 256, REGISTRAR'S S | IGNATURE (|
| | Netto A Haight Surking | elle 9 | M. DATE DELLE | S 01 Culled | J. Flrank |
| 120 | | - | | | |



Year

196/

(Stote)

DATE SIGNED

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| The part to the part of the pa | THOSE DISTRICT CONTROL ASSESSED AS |

VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| 13750 | CERTIFICA | ATE OF DEATH | Reg. Dis | HARTOR |
|--|--|--|--|--|
| D. PLACE OF DEATH O. COUNTY CARROLL | MARYLAND | 2. USUAL RESIDENCE (Where deceased a. STATE) | lived. If institution: Residence b. COUNTY CAS | e before odmission) |
| b. CITY OF TOWN (If outside corporate limits, write: RURAL and give nearest fewn) d. NAME OF HOSPITAL (If not in hospital, give since OR INSTITUTION D. CITY OF TOWN (If outside corporate limits, write) d. NAME OF HOSPITAL (If not in hospital, give since OR INSTITUTION D. CORPORATE (III) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If guiside corpored) d. STREET ADDRESS | ote limits, write RURAL and g | e. IS RESIDENCE ON A FARM? YES NO |
| male white widow | Middle PETER S RRIED NEVER MARRIED D VED DIVORCED D | 1111. 14,18/4 | 87 yrs. Months | Day Year 10 196/ 1 YEAR IF UNDER 24 HRS Days Hours Min. |
| JOA. USUAL OCCUPATION (Give kind of work done 10b during most of working life, even if retired) 3. FATHER'S NAME AS DECEASED EVER IN U. S. ARMED FORCES? | road imply | STRY 11. BIRTHPLACE (State or foreign con 14. MOTHER'S MAIDEN NAME INFORMANT | Address | ZEN OF WHAT COUNTRY |
| 18. CAUSE OF DEATH [Enter only one course per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 14.43 DUE TO Conditions, if any, which gave rise to immediate course (a), stating the undercourse (a), stating the undercourse (a), stating the undercourse lost. Part II. OTHER SIGNIFICANT CONDITIONS | Myorard Hypotu | Color (Chr). TO TRELATED TO THE TERMINAL DISEASE | CONDITION GIVEN IN PART | INTERVAL BETWEEN ONSET AND DESCRIPTIONS OF THE PROPERTY OF THE |
| 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | SCRIBE HOW INJURY OCCURRE | D. (Enter noture of injury in Part I or Part | II of item 1B.) | PERFORMED? YES NO |
| A Hour a.m. While | CALLED AND AND AND AND AND AND AND AND AND AN | ACE OF INJURY (Home, form, ctory, street, office bldg., etc.) | or town) (C | County) (State |
| 21. I certify that I attended the decedative on 2 - 9-19 ACTUAL SIGNATURE S | ased fram | | he causes and an the | st saw the deceased date stated above DATE SIGNED |
| BURIAL CREMATION, 22b. DATE THEREOF / 2 / 13 / 6 | 22c. NAME OF CEMETERY & | PREMIONY 22d. LOCATE | ON (City, town, or county) | (Stote) |

Maple de (lona) Myorond los (Ches). / topportunes -200 60 8 12-10 CI 12-9-61 Postameter feet a new pet 121-4 from C. Josemeth W. O. JEMNETTE NESTAINSTER, MOLIOSEMAINS Pol.

stely filled in by the funeral pers. Pages 1 and 2 should 2 hours after death. within 24 hours after hours aft and in any event, within THEOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be covern. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and condirector, page 3 should be detached for use as the burial-transit permit. Then please remove carbon be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with

VR A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13751 CERTIFICATE OF DEATH 13727

| 1. PLACE OF DEATH a. COUNTY | | | | CE (Where decessed lived, | | dence beforé e | dmission) |
|--|----------------------|-------------------------------|-----------------------------------|--------------------------------|-------------------|----------------|-----------------|
| Carroll | | MARYLAND | Maryla: | nd ь, co | City | | |
| b. CITY OR TOWN (if outside corporate lim write RURAL and give necrest town) | nits, c. L | ENGTH OF STAY IN 18 | c. CITY OR TOWN (| If outside corporate limits, w | rite RURAL end gl | ve neerest tow | n) |
| Sykesville | 44 | rs.7mos.23 | ivs Baltim | ore 15 | 3 V | 01-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION | (if not in hospitel, | give street eddress) | d. STREET ADDRESS | | | | A FARM? |
| Springfield Sta | ate Hospi | tal | 3208 H | ayward Avenue | | | но 🔀 |
| 3. NAME OF First DECEASED | 1 | Middle | Last | 4. DATE Mo | nth D | ay Yee | |
| (Type or print) Mar | garet | Owens | Bieretz | DEATH Decem | ber 1 | 7 19 | 61 |
| 5. SEX 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | B. DATE OF BIRTH | 9. AGE (In year last birthday | Months Dev | | 24 HRS. |
| Female White | WIDOWED [| DIVORCED | July 28, 188 | | Monins Dey | s Hours | Mill. |
| 10a. USUAL OCCUPATION (Give kind of wordone during most of working life, even if retire | k 10b. KIND O | F BUSINESS OR INDUS | TRY 11. BIRTHPLACE (Cour | | ry) 12. CITIZEN | OF WHAT | OUNTRY? |
| Housevife | , | _ | Marylan | đ | U. | S.A. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN | | | | |
| Thomas Owens | | | Mary Ann | Williams | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FO | | AL SECURITY NO. 17. | INFORMANT | Addi | ess | | |
| No - | SOLVICE) | - | Springfie | ld Hospital R | ecords | | .5.119 |
| 18. CAUSE OF DEATH [Enter only on | e cause per line for | (e), (b), end (c).) | | - | | INTERVAL BET | |
| PART I. DEATH WAS CAUSED BY: | Brone | hopneumoni | a. | | | Days | |
| 60 3 DUE TO | | | | | | | |
| Conditions, if eny, which | Renal | insuffici | ency | | | Week | 88 |
| gave rise to immediate cause | | | | | | | |
| (e), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT COND | ITIONS CONTRIBU | TING TO DEATH BUT | NOT RELATED TO THE TERMI | NAL DISEASE CONDITION | SIVEN IN PART 1(a | 19. WAS A | UTOPSY RMED? |
| C.B.Sl associated | with circ | ulatory di | sturbance wit | h cerebral ar | t. with | | NO T |
| C.B.S. associated to a specific and conditions of contributing cause of death of the contribution of contribution of contributions of contribu | 20b. DESCRIBE | HOW INJURY OCCUR | ED. (Enter neture of injury in | Pert I or Pert II of item 18.) | | | |
| OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20c. TIME OF INJURY Month, Dey, Ye | eer 20d. INJUR | | LACE OF INJURY (Home, ferr | | (County) | | (Stete) |
| 건 20c. TIME OF INJURY Month, Dey, You Hour e.m. 19 | | Not While for the street work | ectory, street, office bldg., etc | -) | | | |
| 21. I certify that (I) (this hosp | | | 4-24- | 19 57, to 12- | 17- 1961 | that (1) (| we) last |
| saw the deceased alive on | 12-17- | 1067 and th | at death occured at.1 | | | | |
| 22e. SIGNATURE | | | ar deam occured ar.m | TRANSPORT INC. COURS | 3 4113 611 1110 | | . DATE |
| Danistan e | 101 11 | mho | M.D. ATTENDING | MED. STAFF | 7 | 12 | SIGNED |
| 22c/PHYSICIPIN'S | | // | 22d. ADDRESS | | | | Alex 1 |
| NAME (Type) Agustin | del Campo | , W.D. | Springfiel | d State Hospi | tal, Syk | esvill | e, Mo |
| 230. BUTTAL, CREMATION, 236. DATE THE | REOF 23c. | NAME OF CEMENT | Y OR CREMATORY | 23d. LOCATION (City, | town or county) | (5 | tote) |
| REMOVAL (Specify) | 61 / | hud Ke | de Cometer | | ne 1. | Sur | pland |
| 24 FUNERAL DIRECTOR'S SIGNATURE | 200 0-1 | ADDRESS A | 25e. R | C'D BY REGISTRAR 25b. | REGISTRAR'S SIG | NATURE | |
| John Byles 8: | 128 Jebe | ely 14. Van | dellstren DATEDE | C 2 0 '61 | Inthun 8 to | aug | |
| | | | 749- | | | 1 1 1 1 1 1 | |

Circumstiffed and transfer half og har stock for derest of the assessment its report freezhout the namen area. In dito the first of the property of the contract o The Value of the second control of the Value

uted within 24 hours after etely filled in by the funer TO SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ho debth. Page 4 may be retained by the hospital or attending physician.

S TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and content of the page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and S be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13752 CERTIFICATE OF DEATH

13728

| | PLACE OF DEATH | TO THE RESERVE TO THE | The same | | | 2. USUAL R | ESIDEN | CE (Whare | decaased live | d, If in | stitution: R | asidanc | before e | dmission) |
|---------|--|--|--------------|----------------------------|---------|---------------------|-----------|----------------|-----------------|----------|--------------|---------|------------|-----------|
| | . COUNTY Carr | oll | | MARYLA | IND | a. STATE | Mary | land | ь. С | OUNT | Carr | 011 | | |
| | b. CITY OR TOWN (if | outsida corporate limit giva nearest town) | s, | c. LENGTH OF STAY | IN 1b | c. CITY OF | NWOT | lf outsida co | rporete limits, | writa | RURAL and | give n | earest low | n) |
| | Westmi | | | 4 years | | 2.7 | Westr | ninste | r | | | | | |
| | d. NAME OF HOSPITA | AL OR INSTITUTION (in | not In hosp | pital, giva street address | ;) | d. STREET | ADDRESS | | | | | | | SIDENCE |
| | 68 Wes | t Green St | reet | | | / | 68 W | est Gr | een St | ree | t | | | NO X |
| 3. | NAME OF DECEASED | First | | Middla | | Last | | 4. DATE | ٨ | Aonth | | Dey | Yaar | |
| | (Type or print) | Calvi | | Walter | | Binkl | ey | DEAT | H Dece | mbe | r | 12 | 196 | 61 |
| 5. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8 | DATE OF BIRT | Н | | 9. AGE (In y | 1 1 - | | | IF UNDER | |
| | Male | White | WIDOWE | DIVORCED | | April 8, | 1894 | 4 | 10 | rs. | Months [| Days | Hours | Min. |
| 10a | . USUAL OCCUPATION during most of work | ON (Give kind of work | 10b. KI | ND OF BUSINESS OR IN | | | | | or foraign cou | ntry) | 12. CITI | ZEN OF | WHAT | OUNTRY? |
| | Manager | ang ma, ovan n jonto | | ain Elevato | r | Penn | sylva | ania | | | U. | S.A | | |
| 13. | FATHER'S NAME | | | | | 14. MOTHER'S | - 0 | | | | | | | |
| | Ch | arles N. B | inkley | T | | | Mo | oldv | Brumba | ugh | 1 | | | |
| | WAS DECEASED EVE | R IN U.S. ARMED FOR | CES? 16. 5 | SOCIAL SECURITY NO. | 17. I | NFORMANT | | | Ad | drass | | | | Md. |
| (Ye | No No (If) | /as give war or detas of se | 2 | 14-03-5168 | Mrs | s. Lola | Crawi | ford. | 4.4. W. | Gre | en St | . W | estmi | nster |
| - | | ATH (Entar only one | causa per li | na for (a), (b), an del | | 011 | | , | | 1 | | INT | RWAL BET | NEW |
| | | WAS CAUSED BY: | (1 | 51 M | 0 | 1810 | 222 | mo | つかん | a | De | PON | ET AND | en |
| | 331 | DUE TO | | | | 2 4 10 | 1-11 | 1.1.10 | o Ki | 1 | - | - | - Con-t | |
| | Conditions, if eny, | 1 | | | | | | | 1 | / | | | | / |
| | geva risa to immadia | ta cause | | | | | | | | - | | - | | - |
| | (a), stating the un | darlying DUE TO | | | | | | | | | | | | |
| | ceusa last. |) (c)_ | | | | | | | | | | | | |
| 0 | PART II. OTHER | SIGNIFICANT CONDIT | IONS CON | TRIBUTING TO DEATH | BUT NO | T RELATED TO T | HE TERMIN | NAL DISEAS | E CONDITION | IGIVE | N IN PART | 1(a) 19 | . WAS A | RMED? |
| CAT | | | | | | | | | | | | Y | ES 🗌 | NO Z |
| ERTIFIC | 20e. ACCIDENT WA | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DESC | CRIBE HOW INJURY OF | CCURED | . (Entar netura of | injury In | Pert I or Pert | Il of item 18. |) | | | 1000 | |
| Į, | 20c. TIME OF INJUR | | - 1204 1 | NJURY OCCURRED 2 | O- DI A | CE OF INJURY (| Hama form | 1 206 10 | ity or town) | - | (Cour | nds.el | | (Steta) |
| EDIC | Hour a.m. | Month, Day, 188 | While | Not Whila | | ory, straet, offica | | | 0 | | (000) | 1177 | | (21018) |
| ME | p.m. | 19 | et work | at work | | 1,4 | . 0 | 1,, | M | 1 | 9 | 1 | | |
| | 21. I cortify th | at (I) (this hospit | attend | dogs the deceased | from. | jus, | 20 | 194/ | ofthe | -full | 196 | Day 11 | at (1) (| we) last |
| | saw the decease | d alive on | ac 1 | 19 6, an | d that | death occur | od My | John tro | m the cau | ses a | and on t | he dat | Pe state | d above. |
| | 220 STUNATHETY | 1 700 | | 11. | | ATTENDIN | 6. | wet). | STAFF | | | 197 | 225 | SIGNED |
| | 1 4 | Tr. MIN | Se | W/ | M | D. PHYS. | 1 | DIRECTOR | PHY5. | 4 | 1 | 120 | CK | GH |
| | NAME (Type) | WINAI | - 90 | SIFO | - | 22d. ABD | 2459 | . * | 1 | 70 | 116 | 11 | 20 | N |
| | 1 James Coppell | 11/11/ | -01 | 0000 | | | 1// | un | V | 12 | rein | 17 | // | 14 |
| 23 | DURIAL, CREMATIC | ON, 236. DATE THER | IOI | 23c. NAME OF CEM | ETERY (| OR CREMATOR | | 3d. 10 | CATION (Cir | y, tow | n of county | | | lele) |
| | REMOVAL (Spacify) Burial | 12/15/ | 61 | Pipe Creek | c Ce | metery | | New | Windso | r, | | Ma | ryla | nd |
| 24 | FUNERAL DIRECTOR | SIGNATURE | | ADDRESS | | | 25a. REC | 'D BY REGI | STRAR 256 | REG | ISTRAR'S | HENAT | URE | |
| | C. Fuss | & Son | Tan | eytown, Md. | | | DATE | DEC 18 | 01 | | 2 | | | |
| | | | | | | | | | | | | | | |

The west of the first of the fi The state of the s THE RESERVE OF THE PROPERTY OF · Confirmation College MARYLAND STATE DEPARTMENT OF HEALTH

| | DIVISION OF STATISTICAL RESE | CERTIFICAT | | | BALTIMO | 13° | -100 |) |
|--------------|---|--|--|-------------------|-----------------------|-----------------------|-----------------------|------------|
| 1. | PLACE OF DEATH | | 2. USUAL RESIDEN | CE (Where de | ceesed livad, If in | stitution: Residen | ce before | admission) |
| | s. COUNTY | | e. STATE | | b. COUNT | Υ | | / |
| _ | Carroll | MARYLAND | Mary | | | Washi | ngton | |
| | b. CITY OR TOWN (if outside corporete limits, write RURAL end give nearest town) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (| It outside corpo | prata limits, writa i | RUKAL and give | neerest tov | rn) |
| | Sykesville | 19 Yrs | Maugans | ville | | 21x | (. 2 | |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in h | ospital, give straet addrass) | d. STREET ADDRESS | | | | | ESIDENCE |
| | Springfield State Hospit | al | _ | | | | YES _ | NO D |
| 3. | NAME OF Luther First | Middle | Last | 4. DATE OF | Month | Day | Yea | ir. |
| | (Type or print) Pearre | | Boyer | DEATH | 12 | 9 | | 61 |
| 5. | SEX 6. COLOR OR RACE 7. MARK | RIED NEVER MARRIED B | . DATE OF BIRTH | | 1 | Months Deys | Hours | R 24 HRS. |
| | Male White WIDOV | VED DIVORCED | July 28, 19 | 03 | 氏名 yrs. | Monins Days | Honts | Mill. |
| | | KIND OF BUSINESS OR INDUSTR | Y 11. BIRTHPLACE (Cour | nty & Stata, or f | oreign country) | 12. CITIZEN C | F WHAT | COUNTRY |
| de | ne during most of working life, even if retired) Plumber | - | Maryland | | | U.S. | Α. | |
| 13. | FATHER'S NAME | | 14. MOTHER'S MAIDEN | NAME | | | | |
| | Charles Boyer | | Anna | Catheri | ne Artz | | | |
| 15. (Ye | WAS DECEASED EVER IN U.S. ARMED FORCES? 1s, no. or unknown) (Ifyasgivewarordetesofservice) | | Springfield | Hospita | Address 1 Record | ls | | |
| | Conditions, if any, which (b) geve rise to Immadiate ceuse | r line for (e), (b), end (c).] | | | | | TERVAL BE | |
| | (a), steting the undarlying cousa last. | | | | | | | |
| CATION | PART II. OTHER SIGNIFICANT CONDITIONS CO Psychosis with syphilit. | ontributing to death but no ic meningo-ence | phalitis. | NAL DISEASE C | CONDITION GIVE | 42 | PERFO | NO X |
| CERTIFICATIO | 208. ACCIDENT WAS UNDERLYING DOR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | . (Enter neture of injury in | Part I or Pert II | of item 18.) | | | | |
| MEDICAL | Hour a.m. Wh | ile Not While fact | CE OF INJURY (Home, farr ory, straet, office bldg., atc | :.) | | (County) | | (Steta) |
| | 21. I certify that (I) (this hospital) attes | r 9 1961, and that | October 1, | 1942 to. | the causes a | 9, 1961, and on the d | that (I) ate state | (we) las |
| | 228. SIGNATURE | 0 | | , | | | | b. DATE |
| | agustin del | Christo. " | | MED. DIRECTOR | STAFF PHYS. | | 1 | 2/10 |
| | 224. PHYSICIAN'S NAME (Type) A CTISTING COLUMN | Comma (As 5) | 22d. ADDRESS | ala II a | -: 4-7 C | 4 | 3//-3 | |

derfit. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and conditioning physician and conditioning page 3 should be detached for use as the burial-transit permit. Then please remove carbon be filed with the State Dept. of Health prior to hurial creasion. The law requires that the death certificate be VR A15 (4) 15M 9/60

filled in by the funeral Pages I and 2 should

hours after death



12/13/61 Buria? 24 FUNERAL DIRECTOR'S SIGNATURE

23a. BURIAL, CREMATION, REMOVAL (Spacify)

Dunkard Cemetery ADDRESS

23c. NAME OF CEMETERY OR CREMATORY

Agustin del Campo, M.D.

23b. DATE THEREOF

Proadfording Wash Co Md

258. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE

DEC 1 2 '61

Outhur 8 House

Springfield Hospital, Sykesville, Md. 23d, LOCATION (City, town or county)

arthur S. Krans

161

(State)

13754 . If fancours to White of the feet the abouton. And additional first to a rate of the Anapolitan and and and Burger | 13/13/61 Dunderd Countsty | prostroing Vasa in | 17 M. No of Min and Museum and Me 2 as the 2 miles

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH director, illed with PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY be filed MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) should ESTM d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION NAME OF First Middle Month DECEASED (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS. 9. AGE (In years lost birthdoy) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Months DIVORCED [WIDOWED | yrs. 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME RSEY IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT affendin 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) **DUE TO** þ Conditions, if ony, which (b) gove rise to immediate DUE TO couse (o), stoting the underte has been sig lying couse lost. 0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18.) 20c. TIME OF INJURY Month, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Doy, Year (County) foctory, street, office bldg., etc.) Hour o. m. While Not while of work of work 21. I certify that (1) (this haspital) attended the deceased fram.... , and that death accurred at 350 M, from the causes and on the date stated above. saw the deceased alive an TO FÜNERAL DIRECTOR: 22o. SIGNATURE ATTENDING PHYS. DIRECTOR -M.D. 22c. PHYSICIAN'S NAME (Type) 23d LOCATION (City, town, or county) BURIAL, CREMATION, 23b. DATE THEREOF CEMETERY OR CREMATORY page REMOVAL (Specify) THERAL DIFECTOR'S SIGNATURE ADDRESS 2So. REC'D BY REGISTRAR 25h. REGISTRAR'S SIGNATUR

e. IS RESIDENCE

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO NO

> > (Stote)

22b. DATE

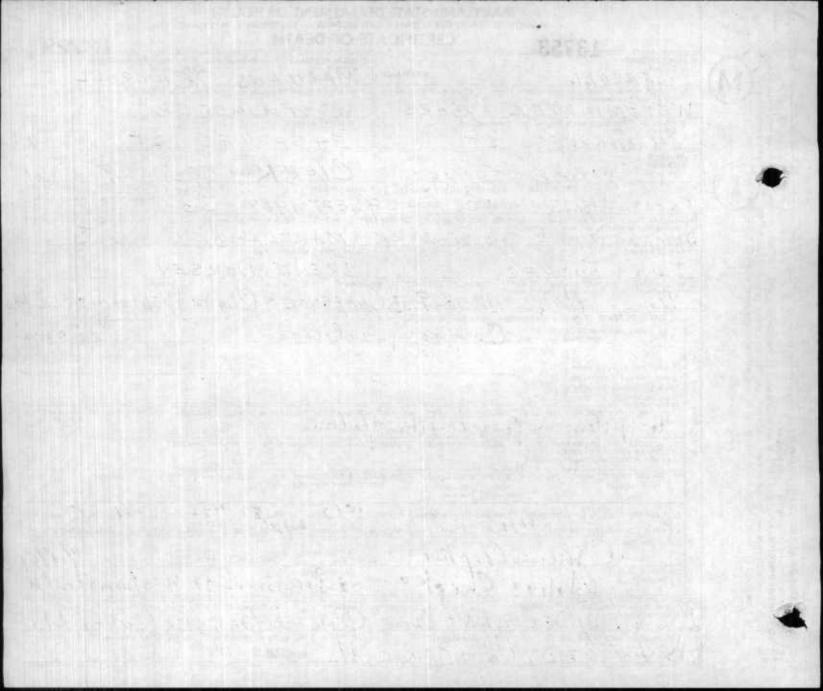
arthur & House

ON A FARM? YES NO NO

Yeor

19/0

VR A15 (4) 1SM 9/59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

IS RESIDENCE

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

35 YEAR

YES NO

(Stote)

(County)

ON A FARM? YES NO 4

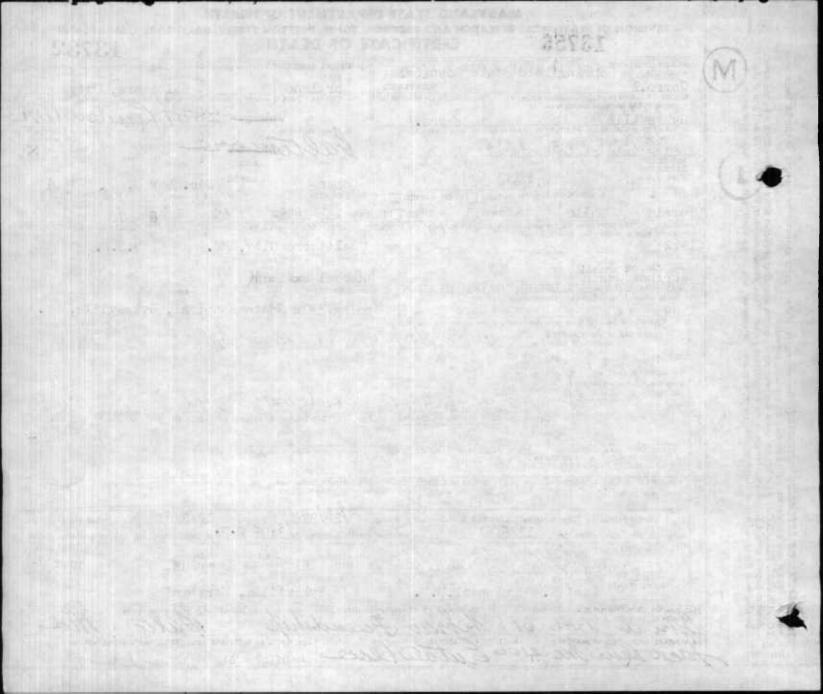
PERMITTED AND THE RESIDENCE OF THE PROPERTY OF THE MERCH CONCESTINE HEART FAILURE SAR FORMUNEER AND ANYMA ANYMAN

VR A1S (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13735 CERTIFICATE OF DEATH 13732

| П | 1. PLACE OF DEATH Springfield State Hospital | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) |
|----|--|---|
| 7 | Carroll MARYLAND | o. STATE Maryland Baltimore, City |
| | b. CITY OR TOWN (if outside corporate timits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| 51 | C-1 | unknown 2507 Leudew Uve |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d ATREET ADDRESS o. IS RESIDENCE |
| | Springfield State Hospital | Galting 3VOI-4 YES NO NO |
| | 3. NAME OF first Middle | Last 4. DATE Month Day Yeer |
| | DECEASED (Type or print) | OF DEATH |
| | Flora | December 5. 1961 |
| | 7. MARRIED NEVER MARRIED | DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| | | May 15, 1896 65 yrs. 8 7 |
| П | 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Y 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | Clerk | Baltimore City, Md. U.S.A. |
| | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| | Abraham Cohen | Rachel Pallocal |
| 1 | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I | |
| | 4.7 | pringfield State Hospital, Sykesville, Md. |
| | 18. CAUSE OF DEATH Enter only one cause per line for (e), (b), and (c).] | INTERVAL BETWEEN |
| 1 | PART I. DEATH WAS CAUSED BY: MYN O BOD | U INITIONATION ONSET AND DEATH |
| | IMMEDIATE CAUSE (a) 11 YO C 13 R 157 F | THE THE CATORY TRANS |
| | DUE TO | |
| | Conditions, if eny, which geve rise to immediate cause | |
| | (e), stelling the underlying DUE TO | a Denovine Comment and mo |
| | causa last. (c) STHT TOPHICENIC | KTACION CHIVINIE 1899 11105. |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| Н | <u> </u> | YES NO INC. |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 200. ACCIDENT WAS UNDERLYING 200. DESCRIBE HOW INJURY OCCURED. OP CONTRIBUTING 2AUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | (Enter neture of injury in Part I or Part II of item 18.) |
| | | CE OF INJURY (Home, ferm, 1 20f. (City or town) (County) (State) |
| 1 | 0 1 | ry, street, office bldg., etc.) |
| | 21. I certify that (I) (this hospital) attended the deceased from | 3/28/27, 19, to 12/5/61, 19, that (I) (we) last |
| Н | saw the deceased alive on 12/5/61 19 and that | death occured at 3:05, From the causes and on the date stated above, |
| | 22e. SIGNATURE | 22b. DATE |
| | may h. Dunkingal " | ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. T |
| | 22c. PHYSICIAN'S | 22d. ADDRESS |
| Н | Name (Type) Naci N. Buyukunsal, M.D. | Sykesville, Maryland |
| | | CREMATORY / 3d. LOCATION (City Jown or county) 5 (State) |
| | MANUAL (Specify) 12-6-61 Nebrew 7 | wendship talto Mo |
| 1 | VIUNERAL DIRECTOR'S SIGNATURE ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| 1 | tack Leurs Mc 2100 E jetan Pl | DATE DEC 7 '61 Curion of Thomas |
| 1 | | Tomas and I constant to tomas |



VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

| | 12757 | CERTIFICA | IE OF DEATH | 12722 | |
|---|---|----------------------------|--|---|--|
| Ì | 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where | deceased lived. If institution: b, COUNTY | Residence before admission) |
| Į | (arroll | MARYLAND | Mayla | Nd | Jarroll |
| | b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outsi | ide corporate limits, write RURA | L and give nearest town) |
| 1 | HAMPSTEAD | 4910 | X /VAMIPS | TEAD | |
| 1 | d. NAME OF HOSPITAL (If not in haspital, give street of NAME OR INSTITUTION | oddress) | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? |
| | 229 M MAIN | | 229 M. | MAIN | YES NO |
| 1 | 3. NAME OF DECEASED | Middle | 1 1 | DATE Month | Day Year |
| ŀ | (Type or print) William S. SEX 6. COLOR OR RACE 7. MARR | EARL L | B. DATE OF BIRTH | DEATH Dece in La | JNDER 1 YEAR IF UNDER 24 HRS. |
| | Male Wille Willowe | | Sept 17, 189 | 4 . 4 . 4 | onths Doys Haurs Min. |
| Ì | 10a. USUAL OCCUPATION (Give kind of work done 10b. | | STRY 11. BIRTHPLACE (Stote or I | | 12. CITIZEN OF WHAT COUNTRY? |
| ı | during flost of wasking life, even if retired) | r dothing | Manda | vd | Us.A. |
| | 13. FATHER'S NAME | 1 | 14. MOTHER'S MAJOEN NAM | E | |
| | William A. DAV. | Idson | L1/12/ | Yay Shiple | 4 |
| | (Yes, no, or unknown) (If yes, give war or dates af service) | | FORMANT | Address | / |
| | | 4-32-6633 1 | Irs Doris Dr | ANICSON 17/ | MISTEAD |
| | 18. CAUSE OF DEATH [Enter only one cause per lin PART I. DEATH WAS CAUSED BY: | ne for (a), (b), and (c).] | 12/2 | 1-00 | INTERVAL BETWEEN ONSET AND DEATH |
| 1 | 1MMEDIATE CAUSE (a) 447 V DUE TO | exenvar | 2 de nemox k | aye | 72-14-61 |
| ١ | Conditions, if any, which) (b) The | healine / | India Vanne | elen De ser | e? |
| 1 | gave rise to immediate couse (o), stoting the under- | C | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| 1 | lying couse lost. (c) | | | | |
| 1 | PART II. OTHER SIGNIFICANT CONDITIONS C | CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINA | L DISEASE CONDITION GIVEN | N PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| ı | PART II. OTHER SIGNIFICANT CONDITIONS C | | | | YES NO |
| | OR CONTRIBUTING CAUSE OF DEATH | CRIBE HOW INJURY OCCURRED |). (Enter nature of injury in Part | I ar Port II af item 1B.) | |
| | | JURY OCCURRED 20e. PL | CE OF INJURY (Home, form, | 20f. (City or town) | (County) (Stote) |
| | Hour a. m. 19 While at work | Not while | tory, street, office bldg., etc.) | | |
| | 21. I certify that (I) (this haspital) attend | ed the deceased fram. | NUV 14 195 | T. to Dec 18 | 1961, that (1) (we) last |
| 1 | saw the deceased alive an Dec 17 | 19_4, and that d | eath accurred at 35 AM | , fram the causes and c | |
| | 220. SIGNATURE | | ATTENDING MED. | STAFF _ | 22b. DATE SIGNED |
| | 22c. PHYSICIAN'S | in | V.D. PHYS. DIRECT | TOR PHYS. | 1 |
| | NAME (Type Joseph E B | ush MD | HAMBS | FAD / | laryland. |
| f | 23g. RUBIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 12-21-61 | 23c. NAME OF CEMETERY O | Maria | d. LOCATION (City, town, or co | (State) |
| - | 24 FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | The description of the state of | | IR'S SIGNATURE |
| | Lipton Cline - It | unpolled ! | MU DATE | Comm | 1 25, / CARMA |

A Committee of the control of the co THE PROPERTY OF THE PARTY OF TH

03

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | 13758 | CERTIFICAT | E OF DEA | 1411 | 1375 | 24 |
|---|---|--|---|-----------------------------------|------------------------|---------------|
| 1. PLACE OF DEATH | I . | | 2. USUAL RESIDE | ENCE (Where decessed lived, | | ore admission |
| Carroll | | MARYLAND | Marylar Marylar | b. CO | COMICO WIFE | 1 4 44 |
| b. CITY OR TOWN (| if outside corporate limits, | c. LENGTH OF STAY IN 16 | | N (If outside corporete limits, w | | town) |
| Henryton | giva neerest town) | 147 days | Pocomok | | 10 V. | 2 |
| | TAL OR INSTITUTION (if not in | | d. STREET ADDRE | | 200 | S RESIDENCE |
| | n State Hospi | | | | | ON A FARM? |
| 3. NAME OF | First | Middle | Route # | 4. DATE Mo | | Yeer NO |
| DECEASED (Type or print) | | | | OF _ | | |
| | James | | irkson | DEATH Dec | | 19 61 |
| 5. SEX | 6. COLOR OR RACE 7. MAI | RRIED X NEVER MARRIED 8 | . DATE OF BIRTH | 9. AGE (In year | | IDER 24 HRS. |
| Male | Negro WIDO | WED DIVORCED | 1-2-02 | 59 yrs. | Monnis 2073 Tiour | , Mills |
| done during most of wo | ION (Give kind of work 10torking life, even if refired) | . KIND OF BUSINESS OR INDUSTR | Y 11. BIRTHPLACE (C | ounty & Stele, or foreign country | ry) 12. CITIZEN OF WHA | AT COUNTRY |
| Laborer | | | Pocomok | ce, Maryland | U.S.A. | |
| 13. FATHER'S NAME | Million of the last | | 14. MOTHER'S MAID | | | |
| Elwood Di | irkson | | Grace Di | rkson | | |
| | ER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. | NFORMANT | Addr | ess | |
| | fyes give wer or detes of service) | 201 07 67/19 | | | | |
| Yes | EATH [Enter only one couse p | 201-03-6348 J | ames Dirks | son - Patient | INTERVAL | BETWEEN |
| | H WAS CALLSED BY | | | | ONSET A | ND DEATH |
| | IMMEDIATE CAUSE (a) UAI | rcinoma of the | right lung | g with metasta | 1818 | |
| 163 | DUE TO | | | | | |
| Conditions, if eny | | | | | | |
| geve rise to immedia (e), steting the us | | | | | | |
| couse lest. | (c) | | | | | |
| PART II. OTHER | | CONTRIBUTING TO DEATH BUT NO | T RELATED TO THE TER | MINAL DISEASE CONDITION | | |
| Ž. | | | | | YES T | RFORMED? |
| PART II. OTHER OF CONTRIBUTING OF CONTRIBUTING OF CONTRIBUTING | AS UNDERLYING 20b. | DESCRIBE HOW INJURY OCCURED | (Enter nature of injury | In Pert I or Pert II of item 18.) | 160 | 1 110 [] |
| OR CONTRIBUTING | CAUSE OF DEATH MEDICAL EXAMINER) | | . (| | | |
| | | od. INJURY OCCURRED 200, PLA | CE OF INITIDY (H | (City 1-1) | (C | (Flata) |
| 20c. TIME OF INJU | | | CE OF INJURY (Home, fory, street, office bldg., | | (County) | (Slele) |
| p.m. | 19 et | work et work | | | | |
| 21. I certify t | hat (I) (this hospital) at | tended the deceased from. | July 24, | , 1961, to Dec. | .18., 1961, that (1 |) (we) las |
| saw the deceas | Alive on Dec. | 18, 19.61, and that | death occured at | 2:50 from the cause | s and on the date st | ated above |
| 22s. SIGNATURE | y | | | | | 22b. DATE |
| / | odgars M. 1 | naenleay M | .D. PHYS. | MED. STAFF | 7 | SIGNEE |
| 22c. PHYSICIAN'S | / | / " | 22d. ADDRESS | | | |
| Dr. | Edgars M. Maci | ulans. Sunt. | Henryte | n State Hosp. | Henryton | Md. |
| NAME OF TAXABLE PARTY OF TAXABLE PARTY. | ONA 23b. DATE THEREOF | 23c. NAME OF CEMETERY | | 23d. LOCATION (City, | | (Stote) |
| MEMOVAL ISpecify | 112 14 | 1 Ro. 6 D. | | 101- A | | 0 |
| bull | 11-07 | The state of the s | 13. Cen | | | 1 |
| 24 FU AL DIRECTOR | SIGNATURE | ABORESS - A | . 1/1/ | REC'D BY REGISTRAR 25b. | () | |
| Dans 11 | 001. 1. 11.11.11 | 2 × -110111: 161 | DATE | DEC 2 7 '61 | Chichun S. Thous | |

The state of the THE RESERVE OF THE RE MIN'S CALL Districted atomic obtained Ash to the addition and the The barrier of the state of the the property of the second Revision Com Benegler, M. J. with the way of the state of the series

STATISTICAL RESEA ON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH within 24 hours after 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before edmission) a. COUNTY b. COUNTY MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) à E 3. NAME OF DECEASED OF (Type or print) DEATH BOV 8 S. SFX carbon 6. COLOR OR RACI 9. AGE (In years | IF UNDER 1 YEAR NEVER MARRIED and last birthday) WIDOWED DIVORCED physician 1Da. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS done during most of working life, even if retired) 13. FATHER'S NAME D e 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) | (If yes give wer or detes of service) 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c).] signed by PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) burial-transit DUF TO Conditions, if eny, which (b) geve rise to Immediate causa DUF TO (e), stating the underlying certificate has cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(1) 19. WAS AUTOPSY SE 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of item 18.) OR CONTRIBUTING CAUSE OF DEATH After this 20c. TIME OF INJURY 20d. INJURY OCCURRED | 2De. PLACE OF INJURY (Home, farm, ! 20f. (City or town) Month, Day, Yeer factory, street, office bldg., etc.) While Not While et work at work DIRECTOR: 22e. SIGNATURE ATTENDING DIRECTOR PHYS. PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S 23a. BURIAL, CREMATION, 10 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATUR VR A1S (4) DATEDEC

e. IS RESIDENCE ON A FARM? YES NO T

19

INTERVAL BETWEEN

ONSET AND DEATH

PERFORMED?

NO F

(State)

DATE

(Stete)

SIGNED

12. CITIZEN OF

(County)

IF UNDER 24 HRS.

18762 Mar Marthe E. Eraden - Charles all 1200 DUBLE E BOND WESTMINSTER MO Brief WILL Millioned Sulling Law all the property of the state of the sta

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13750 CERTIFICATE OF DEATH

| 1. PLACE OF DEATH o. COUNTY | | | 2. USUAL RESIDEN | ICE (Where deces | b. COUN | | ence before edmission) |
|--|-----------------|--------------------------|----------------------------------|----------------------|---------------------|----------------|------------------------|
| Carroll | | MARYLAND | Mary | rland | B. COON | Howar | rd |
| b. CITY OR TOWN (if outside corporete lim write RURAL and give nearest town) | its, | c. LENGTH OF STAY IN 1 | c. CITY OR TOWN | (If outside corpore | te limits, write | RURAL end giv | re neerest town) |
| Henryton | | 146 days | Clar | ksville | | 13x | 2 |
| d. NAME OF HOSPITAL OR INSTITUTION | (if not in hosp | | d. STREET ADDRESS | | | | . IS RESIDENCE |
| Henryton Sta | te Ho | spital | Rt. | #32 | | | ON A FARM? |
| . NAME OF Firs | | Middle | Last | 4. DATE | Month | De | y Year |
| (Type or print) Joh | | Albert | Dorsey | OF DEATH | Decem | ber 26 | 19 61 |
| 5. SEX 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | B. DATE OF BIRTH | 9. A | GE (In years | IF UNDER 1 YEA | |
| Male Negro | WIDOWED | | 9-22-1888 | 18 | 73 yrs. | Months Deys | Hours Min. |
| Oe. USUAL OCCUPATION (Give kind of wor | k 10b. KII | ND OF BUSINESS OR INDU | TRY 11. BIRTHPLACE (Cou | nty & State, or for | eign country) | 12. CITIZEN | OF WHAT COUNTRY |
| done during most of working life, even if retir | ed) | | Uarrand | C. Man | F F | U.S. | A |
| Farmer 3. FATHER'S NAME | | | 14. MOTHER'S MAIDEN | Co., Mar | yrand | 0.0 | • 12. • |
| Amos Dorsey | | | | Mary Ha | 17 | | |
| 5. WAS DECEASED EVER IN U.S. ARMED FO | RCFS? 16 | SOCIAL SECURITY NO. 17 | INFORMANT | rary na. | Address | | |
| Yes, no, or unkown) (Ifyesgivewarordatesof | service) | | | | | . 4. | |
| No 18. CAUSE OF DEATH [Enter only on | | | ohn Albert I | orsey - | Patie. | | NTERVAL BETWEEN |
| | | 1 0 1-0 | | | | | ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) | Cor | pulmonale | | | | | |
| DUE TO | | | | | | | |
| | Emph; | ysema, pulm. | tbc., chroni | c myoca | rditis | • | |
| geve rise to Immediate cause (e), stating the underlying DUE TO | | | | | | | |
| | Arte: | riosclerosia | | | | | |
| PART II. OTHER SIGNIFICANT COND | ITIONS CON | TRIBUTING TO DEATH BUT | NOT RELATED TO THE TERM | INAL DISEASE CO | NDITION GIVE | N IN PART 1(a) | |
| | | | | | | | PERFORMED? |
| 20e. ACCIDENT WAS UNDERLYING | 20b. DESC | RIBE HOW INJURY OCCU | RED. (Enter nature of injury in | Part I or Part II of | item 1B.) | | |
| PART II, OTHER SIGNIFICANT COND 200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH OF IF HERE, NOTIFY MEDICAL EXAMINER | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Yo | ear 20d. I | NJURY OCCURRED 20e. I | LACE OF INJURY (Home, far | m. 20f. (City or | town) | (County) | (State) |
| 20c. TIME OF INJURY Month, Dey, You Hour e.m. | While at work | Not While | actory, street, office bldg., et | c.) | | | |
| | | | A110 2 | .61 . D | 26 | 1,61 | 1 . (1) () 1 |
| 21. I certify that (I) (this hosp | ital) attend | led the deceased from | n. A.48.• | 15 a m | ♥.Y.• | , 199.4., | , that (I) (we) las |
| saw the deceased alive onDe | C. 20 | 19.Q.L., and th | nat death occured at | M, from t | he causes a | and on the | |
| 220. SIGNATURE | in mo | contace | M.D. PHYS. | MED. DIRECTOR | STAFF PHYS. | | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S | | / | 22d. ADDRESS | | | | |
| NAME (Type) Edgars | M. Ma | culans | Henrytor | n, Maryl | and | | |
| | | | | | | | |
| RUBIABINE AS DIV 23by DATE THE 12/30 | 0/61 | Locust Met | hodist., | 7Simps | | | (State) |
| RUBIAB SPAR DN 23b DATE THE 12/30 | 0/61 | Locust Met | hodist., | TSimps | onville 25b. REG | ISTRAR'S SIGN | NATURE |
| 1260 4011 | 0/61 | Locust Met | hodist., | TSimps | onville 25b. REG | , Md. | NATURE |

VR A15 (4) 15M 9/60

THE RESERVE AND ASSESSMENT OF THE PARTY OF T Course to Constitute SHELL CHILD, AND CAUSE OF THE COURSE OF THE . infly to the tented int., interest the language of the langu Windred Landerson I I francisco de la financia TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

S > TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and considered filled in by the tuneral signed by the attending physician and considered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 thould be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12761 CERTIFICATE OF DEATH
13737

| 1. PLACE OF DEATS | H | | | 2. USUAL RESIDER | NCE (Where dec | eased lived, If i | | ldence before admiss | sion) | |
|--|---|--------------------------|--|---|---------------------|--------------------------------------|--------------------|-----------------------------------|-------|--|
| Ca | rroll. | Maryland Balto City | | | | | | | | |
| write RURAL and Sykes | if outside corporete limits, d give neerest town) VILLE TAL OR INSTITUTION (if a | 9 _V | LENGTH OF STAY IN 16 2 mthsldaggive street eddress) | c. CITY OR TOWN 151 d. STREET ADDRESS | 1 E. For | | RURAL and g | 3 VOI - 4 | | |
| | eld State H | | | Bal | timore 3 | 30 | | YES NO | | |
| 3. NAME OF | First | | Middle | Last | 4. DATE | Month | | Pay Yeer | | |
| (Type or print) | John | | Patrick | Dougherty | OF DEATH | 12 | 1 | 196 | /_ | |
| 5. SEX Male | 6. COLOR OR RACE 7 | . MARRIED 🛣 WIDOWED 🗌 | NEVER MARRIED DIVORCED | 8. DATE OF BIRTH November, 1 | _ | AGE (In years lest birthdey) 71 yrs. | Months Da | | In. | |
| done during most of we | nion (Give kind of work prking life, even if retired) on B&O R.R. | 10b. KIND (| OF BUSINESS OR INDUST | Ireland | | oreign country) | 12. CITIZ | EN OF WHAT COUN | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDE | | | | U O O O O | - | |
| Pat Doug | hontz | | | Managana | t McDona | old Dane | heater | | | |
| 15. WAS DECEASED EV | ER IN U.S. ARMED FORCE | S? 16. SOC | AL SECURITY NO. 17. | INFORMANT | o menous | Address | nercy | | | |
| (Yes, no, or unkown) (| lf yes give war or dates of ser | vice) | ~ | / 0/ 7 1 TT | | D . 1 | | | | |
| NO LIS CRUSE OF I | DEATH [Enter only one co | - use nes line fo | | pringfield H | ospital | Records | | INTERVAL BETWEE | N | |
| The state of the s | H WAS CAUSED BY: | | | ion | | | | ONSET AND DEAT | | |
| 4-30 | DUE TO | Arterio | sclerotic H | eart Disease | • | | 10.10 | years | | |
| Conditions, if an | y, which) (b) | | | | | | | | | |
| | geve rise to immediate cause | | | | | | | | | |
| (a), stating the s | anderlying | | | | | | | | | |
| | soc.with ci: | | | ot RELATED TO THE TERM ral arterios | | | EN IN PART 1 | (e) 19. WAS AUTO | D? | |
| DP. CONTRIBUTING | | 20b. DESCRIBI | HOW INJURY OCCURE | D. (Enter nature of injury l | n Part I or Part II | of item 18.) | | | | |
| 20c. TIME OF INJU | JRY Month, Day, Yeer | While et work | | ACE OF INJURY (Home, factory, street, office bldg., e | | or town) | (Count | y) (State | 9) | |
| 21. I certify | that (I) (this hospital sed alive on 12- | l) attended | the deceased from | 10/10/52 at death occured at? | 19, to Q5M, from | 12-14 the causes | 19.6 and on the | that (I) (we) a date stated ab | last | |
| 22a. MGNATURE | with de | el C | · h- | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. 3 | | 22b. DA | | |
| 226. PHYSICIAN'S | Agustin de | lCampo, | м.б. | 22d. ADDRESS Spring | field H | ospital | Record | s | | |
| 23a. BURIAL, CREMAT REMOVAL (Specify | 100, 23b. DATE THERE | | e. NAME OF CEMETERY | OR CREMATORY | | Baltes | vn or county) | (State) | | |
| 24 FUNERAL DIRECTO | R'S SIGNATURE L. STOVE PORTS METOL HOLE | | ADDRESS | | EC'D BY REGIST | | OISTRAR'S SIE | | | |

Transaction of the state of the Ten 1 20 34 346 1157 . ascond dyne - allow Tenny with the with the state of the first of the state of THE RESERVE OF THE PARTY OF THE 1-11-31 The state of the s and the moral stance see. 12 cm 15 to 12 20 and 15 to 18 20 and 18 and 1

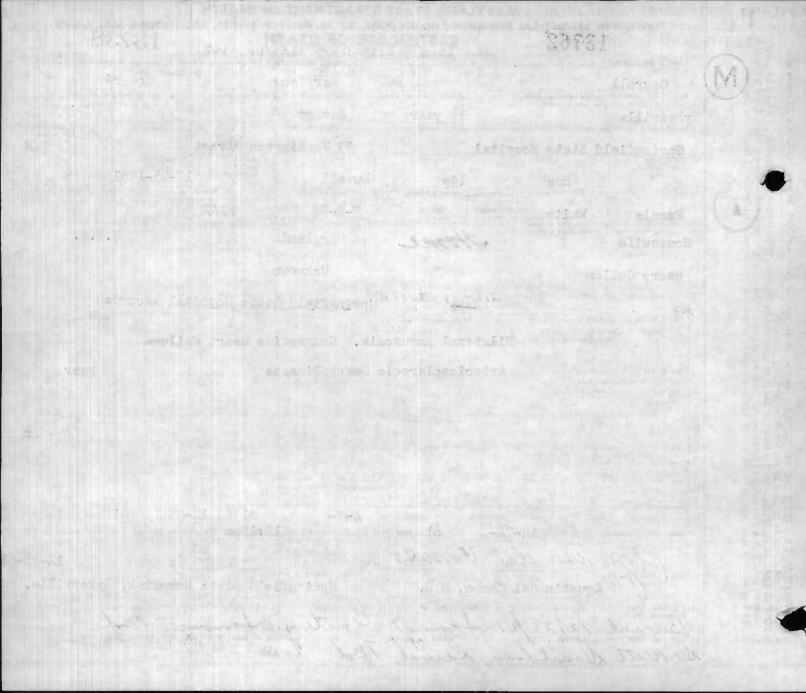
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | 13762 | | CERTIFIC | ATE OF DEA | ATH 1/5/62 iw | k : | 1373 | 8 | |
|---|--|------------------|-----------------------------|--|----------------------------|------------------|-------------------|-----------------|--------|
| . PLACE OF DEAT | н | | | | DENCE (Where decea | sed lived, If Ir | stitution: Reside | nce before admi | ission |
| Carrol | l | | MARYLANI | o. STATE Maryle | and | B. COONI | Howard | L | |
| b. CITY OR TOWN | (if outsida corporate lim d give nearest town) | iits, | c. LENGTH OF STAY IN 1 | c. CITY OR TO | WN (If outside corporat | | | neerest lown) | |
| vkesville | | 100 | 1 years | Savage | | | 13 | x.2 | |
| d. NAME OF HOSPI | TAL OR INSTITUTION | (if not in hospi | tel, give street eddress) | d. STREET ADD | RESS | | | e. IS RESID | |
| Springfie | ald State H | ospita | 1 | 33 Wash: | ington Stre | et | | YES NO | - |
| NAME OF DECEASED | Firs | | Middle | Lest | 4. DATE | Month | Dey | Yeer | |
| (Type or print) | Eva | | Ida | Duvall | DEATH | 12-2 | 5-1961 | 19 | |
| . SEX | | 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH | 9. A | | FUNDER 1 YEAR | | |
| 70 7 - | | | | 7-8-88 | 73/ | st birthday) | Months Days | Hours A | Min. |
| a. USUAL OCCUPAT | ION (Give kind of wor | k 10b. KIN | D OF BUSINESS OR INDU | | County & Stete, or fore | | 12. CITIZEN | OF WHAT COU | NTR |
| done during most of we Housewife | orking life, even if retire | ed) | Home | Maryla | nd | | U.S | S.A. | |
| 3. FATHER'S NAME | | | yome | 14. MOTHER'S MA | | | | | - |
| | | | | Unkn | | | | | |
| Henry Cu | | DC5C2 14 C4 | OCIAL SECURITY NO.1 17 | | OWII | Address | | | |
| | If yes give we rordates of | service) | -18-32081 | d d | d Chata Has | nite] | Records | | |
| No | | | lene | Springrier | a prace mos | broar | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] | | | | | | | | ONSET AND DEATH | |
| LL | PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Bidateral pneumonia. Congestive Heart Failure | | | | | | | | |
| 47 | DUE TO | | | | | | | | |
| Conditions, if en | y, which) (b | Arte | erioscleroti | c Heart Dis | A 2 SA | | | year | |
| geve rise to immed | liete ceuse | | 21 100010101 | 0_110010_210 | | | | 3000 | |
| (e), stating the cause lest. | inderlying | | | | | | | | |
| | R SIGNIFICANT COND | ITIONS CONTI | RIBUTING TO DEATH BUT | NOT RELATED TO THE T | ERMINAL DISEASE COI | NDITION GIVE | N IN PART 1(a) | 19. WAS AUTO | OPS |
| | | | | | | | | PERFORM | ED? |
| 20 ACCIDENT | AS INDERIVING D | 1 201 Dreet | NOT HOW IN THINK O COLL | DED AFTER A LINE OF THE LAND | or to Book Loop Book Host | 74 10 l | | YES NO | |
| OR CONTRIBUTING | AS UNDERLYING A | | RIBE HOW INJURY OCCU | RED. (Enter neture of inju- | ry in Peri I or Peri II of | item 18.) | | | |
| | MEDICAL EXAMINER | | | | | | | | |
| 20c. TIME OF INJU | JRY Month, Dey, Ye | While | | PLACE OF INJURY (Home fectory, street, office bldg | | town) | (County) | (Ste | to) |
| Hour e.m. | 19 | et work | print 1 (0) ((till() print | | | | | | |
| 21. I certify | that (I) (this hospi | ital) attende | ed the deceased fro | m 4-8- | 19 67 to | 12-25 | . 1967 . | that (I) (we |) 2 |
| | | | 19.61, and t | | | | | | |
| 22a. SIGNATURE | 1-/ | 1 / | | iai deain occured | DINE NO. | 10 000303 0 | na on me a | 22b, D | |
| do | uslin o | del | Campo | M.D. PHYS. | MED. DIRECTOR | STAFF PHYS. | | | -2 |
| 22= PHYSICIAN'S NAME TYPE | Agustin d | el Camp | ро, м.б. | 22d. ADDRESS Sprin | gf iel d Stat | e Hosp | ital, S | ykesvill | le |
| 3a, BURIAL, CREMAT RELIDVAL (Specify | 10N, 236. DATE THE | REOF. | Lange OF CEMETER | Cemeter | Jan Jan | ON (City, Inwi | md | (State) | |
| FUNERAL DIRECTO | R'S SIGNATURE | 10, | ADDRESS / | Cy , 25g | REC'D BY REGISTRA | 2%. REGI | STRAR'S SIGNA | ATURE | |
| No WITT | Meno | 1 | Lund | my & | JAN 2 '52 | C | Mind d. 76 | CALLE | |
| | A VARIATE | | a manufacture and the | DOM: | | | | | |

letely filled in by the funeral pers. Pages 1 and 2 should 72 hours after death apers. ACSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and director, page 3 should be detached for use as the burial-transit permit. Then please remove be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any vent, w VR A15 (4) 15M 7/61

uted within 24 hours after



TO FUNERAL DIRECTOR: After this certificate has been signed by the otherwise of the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital an attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely for in by the funeral director page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

| (| D | 13763 | MARYLAND S ON OF STATISTICAL RI CER | SEARCH AND | ARTMENT OF RECORDS — BALTI | | YLAND | 43 | 239 |
|---------------|---|--|---|---------------|--|------------------------|--------------------------|-------------------------|---------------------------|
| | PLACE OF DEATH o. COUNTY | Carroll | N | ARYLAND 2. | o. STATE Md . | here deceased live | b. COUNTY | Residence before Balto. | odmission) |
| | RURAL ond give | Noodbine | | TAY IN 1b | c. CITY OR TOWN (IF C | 1111 | | L ond give neare | .03X |
| | d. NAME OF HOSE | PITAL (If not in haspital, gi | rsing Home | | d. STREET ADDRESS | ine Ma | ymingto | | ON A FARM? YES NOTE |
| | NAME OF DECEASED (Type or print) | Minnie | | ddle 2 | A/CONER | 4. DATE OF DEATH | Month Dec. | 16, Day | Year 9 61 |
| | F. | W. | 1441 | RCED M | ar . 30, 187 | 3 8 | st birthday) M 8 yrs. | | Hours Min. |
| | during most of we | TION (Give kind of work d orking life, even if retired) | O. H. | | Pa. | | 1) | 12. CITIZEN OF V | WHAT COUNTRY |
| | FATHER'S NAME | Francis C | | | | uisa - | | | |
| 15. (Ye | WAS DECEASED E | VER IN U. S. ARMED FORCE (If yes, give war or dates of se | 16. SOCIAL SECURITY (vice) None. | NO. 17 INFO | W-7 | alconer hurst S | | o. 29 Md | |
| Z | Conditions, if gave rise to couse (a), stotin lying couse los | immediate DUE TO | Cirberal Distribus Contributing To | Ment Blit NO | exclusion , a | INAL DISFASE COL | erolye | Q . | SJ9 SG/ WAS AUTOPSY |
| CERTIFICATION | 20a. ACCIDENT N | WAS UNDERLYING | 20b. DESCRIBE HOW INJU | | | TITL VAL | | | PERFORMED? YES NO |
| MEDICAL CE | 20c. TIME OF INJ Haur o. m p. m | FY MEDICAL EXAMINER) URY Month, Doy, Yeo | or 20d. INJURY OCCURRED While Not while of work at work | | OF INJURY (Home, form , street, office bldg., etc | | own) | (County) | (Stote |
| | saw the dece | hat (I) (this haspital ased alive an |) attended the decea LLC 1961, | | 1957 19 th accurred at 71A | | causes and | | |
| | 22c. PHYSICIAN'S | mul & | Had ? | М. С | | IED. ST | AFF HYS. | 10 | 22b. DATE SIGNED |
| 236 | NAME (Type | | Hall | CEMETERY OR C | Ay | 123d. LOCATION | (City, town, or o | ounty) | (Stote) |
| L | Burial | 12/19/6 | Lorrai | | k Cemty. | Woodl | awn Md | AR'S SIGNATURE | |
| | WITZKO, | 4TOI Edmond | ison Ave. | | | C 2 0 '61 | 200, | or S. Kruna | |

section in the section Wall of the state 28 - 1980 , 1980 Pencil Creek Tomoley Samler 78 . 1910 mer 1 County S. Hall

unreal tallage to the Peris Centy. 1 Woodlast Mi. .ova museromon IOIa, month

· Made designation

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 13764 Reg. Dist. No. directar PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE o. COUNTY b. COUNTY MARYLAND funeral b. CITY OR TOWN (If outside corporate limits, write pe c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town shauld d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO 4 NAME OF Middle 4. DATE Last Day Yeor DECEASED OF DEATH (Type or print) EL 1961 IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years lost birthdoy) Months WIDOWED P DIVORCED | comple papers. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) puo carbon 13. FATHER'S NAME physician mary emave. 15. WAS DECEASED EVER IN U. S. ARMED TO CES INFORMANT 16. SOCIAL SECURITY NO ottending 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and INTERVAL BETWEEN ONSET AND DEATH a PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (c) DUE TO by DISEASE Conditions, if ony, gned gove rise to immediate per DUE TO couse (a), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED? 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) o. m. While Not while ot work ot work 21. I certify that I attended the deceased from 12 19 6/that I last saw the deceased and that death accurred at / M, from the causes and an the date stated above. alive an / DIRECTOR: ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL SIGNATURE shauld PHYSICIAN'S NAME (Type) 220. BURIAL CREMATION. 22b. DATE THEREOF 22d, LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) page REMOVAL (Specify) *AUNERAL DIRECTOR'S SIGNATURE* ADDRESS 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

arthur S. Thomas

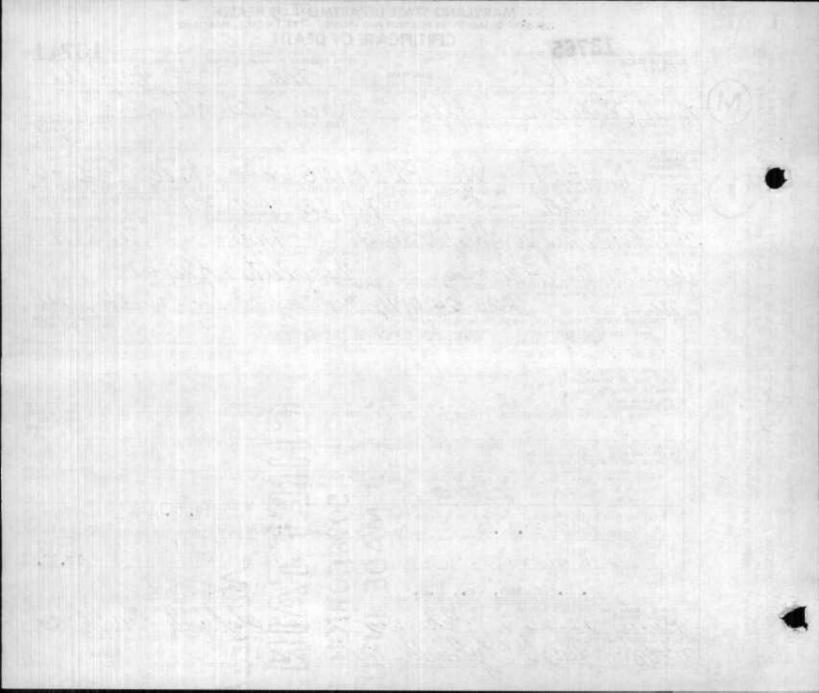
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LABORS DESCRIPTION THE COUNTY OF THE PERSON OF TH

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

| 13765 | CERTIFICAT | E OF DEATH | | 101944 |
|--|---------------------------|--|---------------------------------|--|
| 1. PLACE OF DEATH a COUNTY Carroll | MARYLAND | 2 USUAL RESIDENCE (Where deceased in | b. COUNTY | rall |
| b. CITY OR TOWN (If cytaide corporate limits, write c. RURAL and give neatest town) | LENGTH OF STAY IN 16 | E CITY OF TOWN HI outside corporate | e limits, write ALTRAL and give | e negrest town) |
| d. NAME OF POSETTAL (If not in hospital, give street add OR INSTITUTION | Sirkss) | d. STREET ADDRESS | | e is residence on a farm? YES NO |
| 3. NAME OF DECEASED (Type or print) | N, FLE | MING S 4. DATE OF DEATH | All. | Day Year 22 1961 |
| 6. COLOR OR RACE 7. MARRIED WIDOWED | | DATE OF BIRTH 9. | Land brings de de de | YEAR IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAT OCCUPATION (Give kind of work done 10b. Kg during most of working life, gyen if refired) | ND OF BUSINESS, OR INDUST | RY LI. BIRTHPLACE (State or foreign coun | Tu. | S. A |
| Dermon O. Film | ing | 6 leseletto | Revio | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SO (Par. no. or interjoint) 01 yes, give war or dates in serving) | - 24.0176 | Mrs Mary Alexie | ing - Words | in med. |
| 1B. CAUSE OF DEATH [Enter only one couse per line | | 0 | 6 | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) | MBOLISM OF CO | RONARY ARTERY | | |
| DUE TO | | | | |
| Conditions, if any, which (b) | | | | |
| cause (a), stating the under- DUE TO | | | | |
| lying couse lost.) (c) | TOUR TRUE TO DEATH BUT | TOTAL STATES TO THE TENANT AND THE SECOND OF | CONTRICTION CONTRICTION BART 1 | LI TO WAS AUTORS |
| PART II. OTHER SIGNIFICANT CONDITIONS COLUMN 2003. 20d. ACCIDENT WAS UNDERLYING 20b. DESCRI OF CONTRIBUTING 20bs OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | NIRIBUTING TO DEATH BUT N | NOT RELATED TO THE TERMINAL DISEASE C | ONDITION GIVEN IN PART I | PERFORMED? YES NO |
| | BE HOW INJURY OCCURRED. | (Enter noture of injury in Port I or Port II | of item 18.) | |
| 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY Hour o. m. 19 While of wark [| | CE OF INJURY (Home, form, 20f. (City or pay, street, office bldg., etc.) | town) (Cou | unty) (Stote) |
| 21. I certify that (I) (this haspital) attended | the deceased fram | 1935 19 1ta | 12.22.61 19 | , that (I) (we) last |
| saw the deceased alive an 12.22.61 | 19 and that de | eath occurred at 3:3MP from th | e causes and on the c | date stated above. |
| 22o. SIGNATURE | | | | 22b. DATE SIGNED |
| Cottawam | _ 3 M | .D. PHYS. 🔀 DIRECTOR 🗌 | STAFF PHYS. | 12,22,6 |
| 22c. PHYSICIAN'S NAME (Type) | - 37 TO | 22d. ADDRESS | 35 . 7 . 3 | |
| Wm. H. Lawson, J | r., M.D. | Sykesville-2, | Maryland | |
| 23g. BURIAL, CREMATION, REMOVAL (Specify) 23b, DATE THEREOF 12-26-61 | Sakwin | - minorial Olex | Sull County | Il med. |
| 24 FUNDRAL DIRECTOR'S SIGNATURE | Apokess 11/ 9 | 25a. REC'D BY REGISTRA | R 25b. REGISTRAR'S SIGN | |

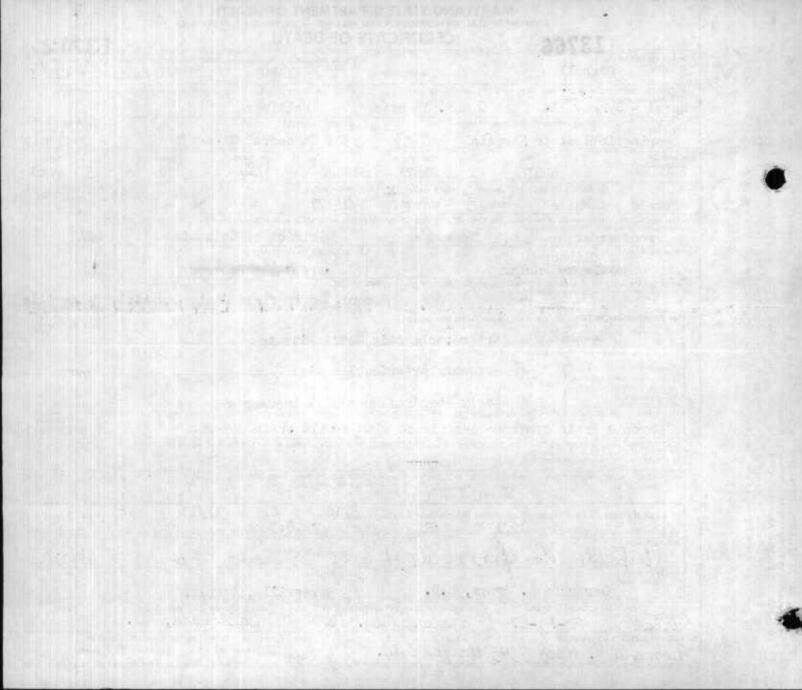


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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

| | I NATE | 13766 | | CEKII | FICA | IE OF D | EAIH | | | | 135 | 112, |
|---------------|--|--|------------------|--------------------------|----------|---------------------|--------------|------------------------|------------------------------------|--------------|------------|----------------------------|
| 1. | PLACE OF DEATH a. COUNTY | Carroll | | MAR | YLAND | 2. USUAL RESI | DENCE (W | here deceased | d lived. If instituti b. COUNTY | | | CIT Y |
| | RURAL and give | (If outside corporate lim | its, write | c. LENGTH OF STA | | c. CITY OR | TOWN (If | outside corpo | rote limits, write R | URAL and gi | ve nearest | town) |
| | Rural - S | ykesville | | | days | | Balti | more | | 3V | 01- | 4 |
| 1 | d. NAME OF HOSE | PITAL (If nat in hospitol, g | give street | address) | | d. STREET A | DDRESS | | | | | RESIDENCE |
| L | Springf | ield State | Hospi | tal | | 517 0 | athec | iral S | treet | | | S NO |
| 3. | NAME OF DECEASED (Type or print) | SUSI | - | Middl ELS | | FOWLER | st | 4. DATE OF DEATH | Mor 12 | | Doy 13 | Year 19 61 |
| S. | SEX | 6. COLOR OR RACE | 7. MAR | RIED NEVER MARR | IED X | B. DATE OF BIRT | Н | | 9. AGE (In years | | | JNDER 24 HRS |
| | Female | White | WIDOW | ED DIVORC | ED 🗆 | 9/15/77 | , | | lost birthday) yrs. | Months D | Days Ho | ours Min. |
| 10 | o. USUAL OCCUPAT during most of wo Proofr | TION (Give kind of work arking life, even if retired | done 10b. | | | | | | ountry) | 12. CITIZI | EN OF WH | AT COUNTRY |
| 13 | . FATHER'S NAME | | | Newspaper | | 14. MOTHER'S | | | DIGMOTA | | UDE | |
| | | Clinton | 1 am | | | | | ueenn | C (1) 21 (1) 22 | | | |
| 15 | | PRINTER FOW | | SOCIAL SECURITY NO | 0 117 IN | FORMANT | A fire | (Read fill) | Add | ratt | | |
| | es. no, or unknown) | (If yes, give wor or dates of s | | SOCIAL SECORITI NO | | _ | ringf | field S | State Hos | | , Syk | esville |
| | 18. CAUSE OF D | EATH [Enter only one co | ruse per li | ne for (o), (b), and (c) |).] | | | | | | INTERVA | L BETWEEN |
| | PART I. DI | EATH WAS CAUSED BY: IMMEDIATE CAUSE (c |) A ₇ | rtereoscle | rotic | Heart 1 | Diseas | 92 | 19 | | CHSEL | NAD DEVIL |
| | 41 | DUE TO | | | | | | | | | | 55 |
| | Conditions, if | ony, which) (E | Co | oronary Ar | terio | scleros | is | | | | Yea | re |
| L | gove rise to couse (a), statin | immediate (| | | | | | | | | | - |
| | lying couse los | - |) E. | arly Termin | nol B | manahin | Pno | monia | | | | |
| NO | PART II. O | THER SIGNIFICANT CON | DITIONS | CONTRIBUTING TO D | EATH BUT | NOT RELATED TO | THE TERM | INAL DISEAS | E CONDITION GIV | EN IN PART | 1(o) 19, W | AS AUTOPSY |
| S A | Chroni | c Brain syn | drome | associate | ed wi | th senil | e bra | ain dis | sease | | | NO [|
| CERTIFICATION | 200. ACCIDENT V OR CONTRIBUTIN (IF EITHER, NOTIF | VAS UNDERLYING IG CAUSE OF DEATH Y MEDICAL EXAMINER) | 20b. DES | CRIBE HOW INJURY | OCCURRE |), (Enter noture o | of injury in | Part I or Por | t II of item 18.) | | | |
| 18 | 20c. TIME OF INJU | JRY Month, Doy. Ye | ar 20d. I | NJURY OCCURRED | | ACE OF INJURY | | | or tawn) | (Cc | unty) | (Stote |
| MEDICA | Hour o. m | 10 | While at wor | | fac | tory, street, offic | e bldg., etc | c.) | | | | |
| ~ | | | | | 1.6 | 5/18 | 16 | 57 | 12/13 | 6- | 1 | |
| | saw the dece | at (1) (this hospita | 12/13 | | | | | 1.19- | the couses an | nd an the | dote sto | (I) (we) los oted above |
| | 22o. SIGNATULE | ude M. | Or | en le | .D. | ATTENDIN | G M | IED. | STAFF PHYS. | | 12 | 226. DATE /13/61 |
| | 22c. PAYSICIAN'S NAME (Type) | Gertrude M | hama | as M D | , | 22d. ADDR | | 17 - M. | | | | |
| 22 | - Duplat opena | | | | | | esvil | | aryland | | | |
| 23 | a. BURIAL, CREMATI REMOVAL (Specif DULLAL | Y) | 51 | Morelan | d Me | n | 2 | 1 12 / | timore, | Md. | | (Stote) |
| 24 | . FUNERAL DIRECTO | R'S SIGNATURE | 5305 | Hartord | Rd. | | | EC 1 8 | | STRAR'S SIGN | 10 | 153.5 |
| - | | | 1 1 | a | | | | | | | | |



CERTIFICATE OF DEATH 13767 Rea. Dist. No. 4 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY filed b. COUNTY Carrol1 MARYLAND Penna. Adams funeral b. CITY OR TOWN (If outside corporate limits, write pe c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) the fune Westminster. Rural 6 Years Littlestown d. NAME OF HOSPITAL (If not in hospital give street oddress) OR INSTITUTION Meadow View Convalescent Home Westminster, Md. R. D. 2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? West King Street YES NO NAME OF Middle 4. DATE Month Day Year DECEASED G. 1961 Mabe 1 Gettier December (Type or print) 19 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH Months Days Hours Female White WIDOWED | DIVORCED | 12/1/1874 papers. yrs. 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired—Housework

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or fareign country)

Retired—Housework

11c. BIRTHPLACE (Stole or fareign country)

State of California 12. CITIZEN OF WHAT COUNTRY? carbon papafter death. State of California U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME C. P. Gettier Elizabeth Myers 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Gettysburg. Mrs. B. A. Miller. 256 Baltimore Street -No None 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH 4 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) lumaria Nau DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO IS 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury of Port I or Port II of item 18.) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day. Year 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) Q. f). Not while of work of work 21. I certify that I attended the deceased from 19.0 __that I last saw the deceased and that death occurred at 1205 P.M. from the causes and on the date stated above. ADDRESS (Street, city or Jown, state) DATE SIGNED ACTUAL P PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) EMOVAL (Specify) Mt. Carmel Cemeterv Littlestown, Adams Co., 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE EC 2 6 '61

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

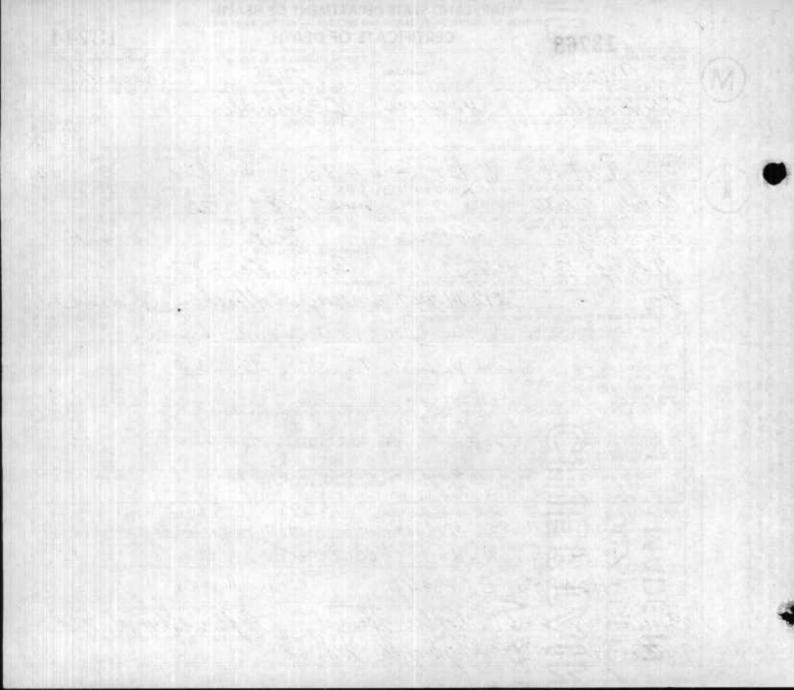
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

13769

13744

| 1. PLACE OF DEATH a. COUNTY ORMAN MARYLA | and 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY |
|--|---|
| b. CITY OR TOWN If outside corporate limits, write ILRAY and give nearest towns III to The There is the There | |
| NAMOF HOSPITAL (If not in hospital, give street oddress) ORMSTITUTION | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\sum \) NO |
| 1. NAME OF DECEASED (Type of print) Ruth First V, E, G | LASS 4. DATE Month Day Year OF DEATH DEC. 3 1961 |
| S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED | 1 June 7, 1889 Tost birthdoy) Months Days Hours Min. |
| 10n. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) | INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| Clay Esworthy | annie Front |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (If yes, give wor or dates of service) 212-14-9267 | Mrs Margaret oftoneling - Of headly ad. |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) When the control of the contro | lure, arthresderder heart des, interval Between |
| Canditions, if any, which) (b) Letter ple can is | h, Cenemia, lumidist 70 |
| gave rise to immediate cause (a), stating the under lying cause last. | . 1961 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH | H BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCUPANTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | CURRED. (Enter noture of injury in Port I or Port II of item 18.) |
| 20c. TIME OF INJURY Manth, Day, Year Haur o. m. P. m. 19 While of work of twark | 0e. PLACE OF INJURY (Home, farm, foctory, street, office bldg., etc.) (City or town) (County) (Stote) |
| 21. I certify that (I) (this haspital) attended the deceased from the deceased alive and 11. 30 19 PM and the | ram |
| 270 SIGNATURE & Wart & Hall' | M.D. PHYS. ATTENDING MED. STAFF ATTENDING DIRECTOR PHYS. ATTENDING DIRECTOR PHYS. |
| PHYSICIAN'S HOWARD E, HALL | 6 Land Address of fresulte, Will |
| 236 BURIAL CREMATION 236 DATE THEREOF 230 NAME OF CEMETE POPULAR 12-6-61 POPULAR | ERY OR COLORATION (City, town, pay County) (State) |
| Justin H. Haight Appears | DEC 6 '61 Chilling & Thomas |



ASSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after doath. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and considerely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60 15

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13760 CERTIFICATE OF DEATH

| 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where decessed fived, If institutions a. STATE b. COUNTY | Residence before admission) | | |
|---|--|--|--|--|
| Carroll MARYLAND | 36 7 3 | V | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | give naerest lown) | | |
| Sykesville lyr.8mos19dy | s. Baltimore 29 | 3x-2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE | | |
| Springfield State Hospital | 1219 Elm Ridge Avenue | YES NO | | |
| 3. NAME OF First Middle DECEASED | Last 4. DATE Month | Day Yaar | | |
| (Type or print) Ada Ann | Hair December | 5 1961 | | |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 | | | |
| 77 79 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | April 5, 1881 So yrs. Months | Deys Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUST | | IZEN OF WHAT COUNTRY? | | |
| done during most of working life, even if retired) Practical Nurse/Midwife - | Tu ul aud | TT CL A | | |
| 13. FATHER'S NAME | England | U.S.A. | | |
| | | | | |
| James Hair | Dorothy Old | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (Ifyesgivewerordelesofservice) | | | | |
| NO | Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] | | ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Bronchopneumoni: | 8 | Days | | |
| 491X DUE TO | | | | |
| Con Data | | | | |
| gave risa to immadiata ceusa | | | | |
| (a), steting the underlying DUETO | | | | |
| cause lest. (c) | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N | IOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART | 1(e) 19. WAS AUTOPSY PERFORMED? | | |
| S C.B.S. associated with senile brain d | isease with psychotic reaction. | YES NO | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BUT N C.B.S. associated with senile brain d; 200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | ED. (Enter neture of injury in Pert I or Pert II of item 18.) | | | |
| ZOc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL | ACE OF INJURY (Home, ferm, 20f. (City or town) (Cou | nty) (State) | | |
| 20c. TIME OF INJURY Month, Day, Year While Not While fe at work 19 at work 19 | ctory, street, office bldg., atc.) | | | |
| 21 I certify that (i) (this hospital) attended the deceased from | 3-16- 19.60 to 12-5- 19 | 67. that (1) (we) last | | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-16, 19.60 to 12-5, 19.61, that (I) (we) last saw the deceased alive on 12-51961, and that death occurred at 1:20, from the causes and on the date stated above. | | | | |
| leave the deceased slive on /=>= 100 f and the | | | | |
| | death occured bracks and on | | | |
| 220. SIGNATURE | M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. | 22b. DATE SIGNED 12-5-61 | | |
| 220. SIGNATURE LES LES LES LES LES LES LES LES LES LE | ATTENDING MED. STAFF | 22b. DATE SIGNED | | |
| Legistin del Campo | M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. | 22b. DATE SIGNED 12-5-61 | | |
| 22c. SIGNATURE 22c. PHYSICIAN'S NAME ((yype) Agustin del Campo, M.D. 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY | M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 22d. ADDRESS Springfield State Hospital, OR CREMATORY 23d. LOCATION (City, fown or count | 22b. DATE 12-5-61 Sykesville, Mo | | |
| 22e. SIGNATURE 22c. PHYSICIAN'S NAME (Yype) Agustin del Campo, M.D. 23s. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Memorial Celegration | M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 22d. ADDRESS Springfield State Hospital, OR CREMATORY 23d. LOCATION (City, fown or count | 22b. DATE 12-5-61 Sykesville, Mo | | |
| 22c. SIGNATURE 22c. PHYSICIAN'S NAME (Yype) Agustin del Campo, M.D. 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) REMOVAL 12-5-61 22c. SIGNATURE CAMPO A.D. 23c. NAME OF CEMETERY Memorial Celebratery | ATTENDING MED. STAFF PHYS. 22d. ADDRESS Springfield State Hospital, OR CREMATORY 23d. LOCATION (City, town or count metery Turner Creek, Pa | 22b. DATE SIGNED 12-5-61 Sykesville, Mo (State) | | |
| 22e. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. 23b. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) REMOVAL 12-5-61 22c. PHYSICIAN'S NAME OF CAMPO, M.D. 23c. NAME OF CEMETERY Memorial Cel | ATTENDING MED. STAFF PHYS. 22d. ADDRESS Springfield State Hospital, OR CREMATORY metery 23d. LOCATION (City, fown or count) Turner Creek, Pa | 22b. DATE SIGNED 12-5-61 Sykesville, Mo (Stete) | | |

PERCHANT JAYONEE

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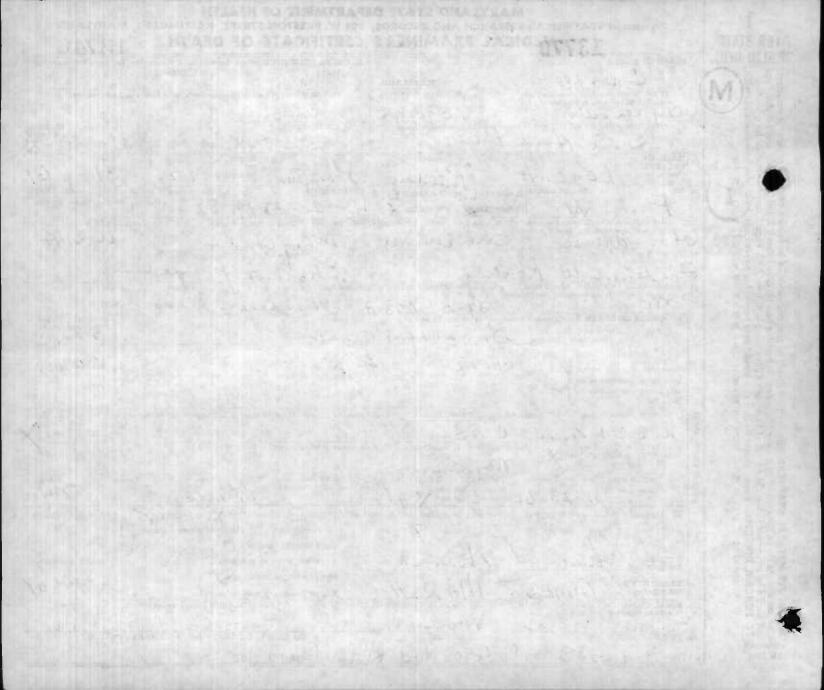
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FOR STATE HEALTH DEPT. please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to tuneral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your filter. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 to each.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| | b. CITY OR TOWN (if outside corporate limits, write RURAL and give negrest town) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) d. STR. 3. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) d. STR. 3. NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF 8 WIDDERS OR HOUSTRY 18. DIVORCED 19. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) 11a. FATHER'S NAME 11a. FATHER'S NAME 11b. SO IAL SECURITY NO. 17 INTORMAN 11b. CRUSE OF DEATH Enter only one cause use line for (a), (b), and (c), part 1, death was caused by immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO SECURITY IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS C | DET ADDRESS A DATE OF DEATH A DATE OF DEATH A DATE OF DEATH PLACE (State or formula country) PLACE (State or formula country) | RURAL end give neerest town) 3 VA - 4 e. IS RESIDENCE ON A FARM? YES NO V Dey Yeer 3 / 19 6/ IF UNDER 1 YEAR IF UNDER 24 HRS. Months Deys Hours Min. |
|--|--|--|--|
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| b. CITY OR TOWN II outside corporele limits, write BURAL end give neerest town) CL | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1. C. LENGTH OF STAY IN 1b 2. C. LENGTH OF STAY IN 1b 3. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) 4. STR 3. NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED NOT RELATED TO DIVORCED A COLOR of the pluring most of working life, even if relired to the pluring most of the pluring most of the pluring most | BACTO. SET ADDRESS 323 SNERWOOD 4. DATE Month OF DEATH / 2 IRTH 2 - 1879 & AGE (In years by birthdey) PLACE (State or forwigh country) ACT MAIN NAME 4. DATE MONTH OF MAIN NAME | ON A FARM? VE. VES NO NO Dey Yes NO IF UNDER 1 YEAR IF UNDER 24 HRS. Months Deys Hours Min. |
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| PRIMARY Or CONTRIBUTING A 20c. TIME OF INJURY Month, Dey, Yeer Hour e.m., D.m. 1/-73 19 6 of work stowers with the stowers of the remains described above, held an Autopsy Inspection Insp | | the second secon | YES NO L |
| 20c. TIME OF INJURY Month, Dey, Yeer Hour e.m., p.m. // - Z 3 19 | PRIMARY or CONTRIBUTING X | injury in Perf I or Perf II of ilem 18.) | |
| Hour e.m. p.m. // - 73 19 (| E CAUSE OF DEATH. / Thopknown | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) 228. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (Siete) | | | (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from. Natural causes, Accident Suicide, Homicide, Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) 228. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stele) | | 1 Dulla | m |
| death resulted from Natural causes, Accident, Suicide, Homicide, Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL, ASSISTANT MEDICAL EXAMINER EXAMINER'S | / / / | psy . Inspection VI. Inquir | and in my opinion |
| CHIEF MEDICAL EXAMINER ACTUAL SIGNATUR SIGNATUR EXAMINER'S NAME (Type) ACTUAL ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) 228. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (Stele) | | | A |
| ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER DATE SIGNED, EXAMINER'S NAME (Type) | | | |
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| NAME (Type) Address (Street, city, town, or county) 228. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stele) | SIGNATURE M.D. AS | SISTANT MEDICAL EXAMINER | DATE SIGNED |
| 226. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (Siete) | EXAMINER'S DEP | UTY MEDICAL EXAMINER | 12/3//6/ |
| | NAME RYPOR JAMES / 11/A RSTT Ad | | 14/6/ |
| | 226. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATOR REMOVAL (Specify) | 22d. LOCATION (City, lown, | or country) (Stele) |
| BURIAL 1-3-62 WOODLAWN BAUTO. CO MD. | | BAUTO CO | MO |
| 23. FUNERAL DIRECTOR ADDRESS , 240. REC'D BY REGISTRAR'S SIGNATURE | | | |
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VS. AISME 5M 7/59



VR A15 (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13771

CERTIFICATE OF DEATH

13747

| 1. PLACE OF DEATE | 4 | | | VCE (Where deceased lived, b. COL | | idence before edmission) |
|--|---|----------------------------------|--|--------------------------------------|-----------------|--------------------------|
| Carroll | | MARYLAND | a. STATE Marvla | | Washing | t on |
| b. CITY OR TOWN (| if outside corporate limits, | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN | (If outside corporete limits, w | ite RURAL end | give nearest town) |
| Sykesy | | 3 years | Hager | stown | 2 | 103-2 |
| | TAL OR INSTITUTION (if not in | hospitel, giva street address) | d. STREET ADDRESS | 5 | | e. IS RESIDENCE |
| Spring | field State Ho | spital | 264 F | rederick St. | | YES NO |
| 3. NAME OF DECEASED | First | Middle | Last | 4. DATE Mor | ith | Dey Yeer |
| (Type or print) | Lillian | | Hines | Decen Decen | | 21 1961 |
| 5. SEX | 6. COLOR OR RACE 7. MA | RRIED NEVER MARRIED 8 | . DATE OF BIRTH | | IF UNDER 1 Y | |
| Female | Tillo 4 4 a | OWED DIVORCED | 3-29-04 | last birthday 57 yrs. | Months Da | ys Hours Min. |
| 10a. USUAL OCCUPAT | ION (Give kind of work orking life, even if ratired) | b. KIND OF BUSINESS OR INDUSTR | Y 11. BIRTHPLACE (Cou | unty & State, or foreign countr | y) 12. CITIZI | EN OF WHAT COUNTRY? |
| Housek | eeper | - | Maryl | | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN | NAME | | |
| Eugene D | avis | | Rillio | e Dixon | | |
| 15. WAS DECEASED EV | ER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. 1 | NFORMANT | Addre | iss | |
| NO | fyes give wer or detes of service) | | Saninafiald | Hospital Reco | nda | |
| | EATH [Enter only one cause | per line for (e), (b), end (c).) | Ph. Tigr rera | HOSPITAT MAGG | itus | INTERVAL BETWEEN |
| | H WAS CALISED BY. | | | | | Months |
| 1 | IMMEDIATE CAUSE (0) | CA of Cervix | | | | Monens |
| 1711 | DUE TO | | | | - 1 | 74409164 |
| Conditions, if eny | (-) | | | | | |
| gave rise to immed (e), steting the u | DUE TO | | | | | / |
| cause last. | (c) | | | | | |
| Z PART II. OTHE | R SIGNIFICANT CONDITIONS | CONTRIBUTING TO DEATH BUT NO | T RELATED TO THE TERM | INAL DISEASE CONDITION G | IVEN IN PART 1 | (a) 19. WAS AUTOPSY |
| C.B.S. as | sociated with | alcohol intoxica | tion with p | sychotic react | ion. | PERFORMED? |
| OP. CONTRIBUTING | AS UNDERLYING 20b. CAUSE OF DEATH MEDICAL EXAMINER) | DESCRIBE HOW INJURY OCCURED | . (Enter neture of injury in | Pert I or Pert II of item 1B.) | | |
| | | OL INTURY OCCUPANTS - OC. BLA | Cr Or INITIAN CH t- | rm, 1 20f. (City or town) | (County | y) (State) |
| ZOC. TIME OF INJU- | . \ | | CE OF INJURY (Home, fer ory, street, office bldg., et | | (Count | (31010) |
| | hat (I) (this hospital) a | ttended the deceased from | 12-11- | 1958 to 12-2 | 7- 196 | that (I) (we) last |
| 21. I certify i | 12-1 | 21- 19.61 , and that | J | :25, p.m. | and an Ab | and the stated above |
| | sed alive on | x.# | death occured att. | | s and on the | 22b. DATE |
| again Signature | 22% SIGNATURE ATTENDING MED. STAFF SIGNED PHYS. DIRECTOR PHYS. SIGNED | | | | | |
| NAME (Type | | | 22d. 'ADDRESS | | | |
| Chamily of | Agustin del (| Campo, M.D. | Springfie | ld State Hospi | tal, Sy | kesville, Md |
| | ON, 23b. DATE THEREOF | 23c. NAME OF CEMETERY | OR CREMATORY | 23d. LOCATION (City, | fown or county) | (Stete) |
| REMOVAL (Specify) | DEC. 23.196 | 1 ROSE HILL | CEMISTIERY | HALERSTON | N MACI | . n. MI2 |
| 24 FUNERAL DIRECTOR | | ADDRESS | 25a R | C'D BY REGISTRAR 25h. | | |
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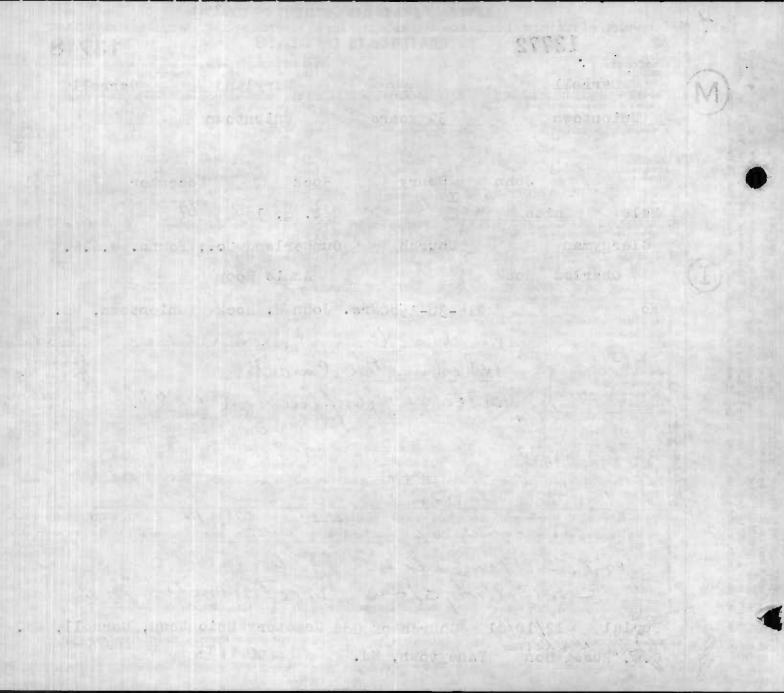
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| Mining Server Agency | MATTOWN | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13772 CERTIFICATE OF DEATH **DIVISION OF** 13748

| 1. PLACE OF DEATH | | | a. STATE | b. COUNT | nstitution: Residence before admission) |
|--|---|------------------------------|--|-------------------------------------|--|
| | roll | MARYLAND | Mar | yland | Carroll |
| b. CITY OR TOWN (| if outside corporete limits, I give nearest town) | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN | (If outside corporate limits, write | RURAL and give nearest town) |
| Unior | | 39 years | X IIni | ontown | |
| | TAL OR INSTITUTION (if not in | | d. STREET ADDRESS | | IS RESIDENCE ON A FARM? YES NOX |
| 3. NAME OF DECEASED | First | Middle | Last | 4. DATE Month | Dey Yeer |
| (Type or print) | John | Henry | Hock | December December | r 7 1961 |
| 5. SEX | 6. COLOR OR RACE 7. MAR | RIED X NEVER MARRIED 8 | DATE OF BIRTH | 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. |
| Male | White WIDO | | Oct. 4. | 189/1 67 yrs. | Months Days Hours Min. |
| 10a. USUAL OCCUPAT | | KIND OF BUSINESS OR INDUSTR | | unty & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Clergy | | Church | Cumbanla | nd Co., Penns | TT C A |
| 13. FATHER'S NAME | 1110011 | Ollal Oll | 14. MOTHER'S MAIDE | N NAME | U.S.A. |
| Cha | rles Hock | | Annie | Roop | |
| 15. WAS DECEASED EV | ER IN U.S. ARMED FORCES? | 6. SOCIAL SECURITY NO. 17. I | | Address | |
| No No | fyesgive wer or detes of service) | 7), 26 7 E80Mmg | . John H. | Hook IInton | tawn Wa |
| | DEATH [Entar only ona cause po | T/1-30-1300MIT'S | • a Our II • | HOCK UNION | ntown, Md. |
| | H WAS CAUSED BY: | · · · · · · · · · · · | . 0 . | Diag | ONSET AND DEATH |
| 1115 | IMMEDIATE CAUSE (e) | reces - vas | curar | - wisere | e aus am |
| 7107 | DUE TO | 1 4' | R 1' | + | many |
| Conditions, if eny | (0) | neumale | Cardi | Mi | yearago |
| gave rise to immed (a), steting tha u | DUIT TO | + 1 11 | 10 | 11 1.1 | 1) /2. 18 |
| causa last. | 1 (0) | Mack 711 | ufluen | 12A /1-41 | 1 3 warrag |
| PART II. OTHE | R SIGNIFICANT CONDITIONS | ONTRIBUTING TO BEATH BUT NO | T MATED TO THE TERM | DISEASE CONDITION GIVE | N IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
| OR CONTRIBUTING | AS UNDERLYING 20b. E CAUSE OF DEATH MEDICAL EXAMINER) | DESCRIBE HOW INJURY OCCURED. | (Enter nature of injury i | n Pert I or Pert II of item 18.) | |
| 20c. TIME OF INJU Hour a.m. p.m. | W | | CE OF INJURY (Home, fe ory, street, office bldg., e | | (County) (State) |
| 21. I certify t | hat (I) (this hospital) att | ended the deceased from. | 105.15 | 1961, to 12-7 | , 196. f, that (1) (we) last |
| | | | | 30 | and on the date stated above. |
| 22a, SIGNATURE | | | | | 22b. DATE |
| n A | 4/3:11: | - alea M. | ATTENDING PHYS. | MED. STAFF | SIGNED |
| 22c. PHYSICIAN'S | a min | The man | 22d. ADDRESS | , , 0/ | 2 |
| NAME (Type | C.6.13/11 | 065/09 | West | minustry, | mil |
| 23a. BURIAL, CREMAT | ION, 236. DATE THEREOF | 300 NAME OF CEMETERY | OR CREMATORY | 23d. LOCATION (City, tow | n or county) (State) |
| REMOVAL (Specify) Burial | 12/10/61 | Church of G | od Cemeter | ry Uniontown, | Carroll. Md. |
| 24 FUNERAL DIRECTOR | SAGNAMA | Church of G | 25e. R | EC'D BY REGISTRAR 256. REGI | ISTRAR'S SIGNATURE |
| John | 14 BRUCKE | aneytown, Md. | 1 | DEC 11 '61 C | Thurs d. Thanks |
| y | 1990 0011 1 | arroy bowin, ma. | DATE 3 | | |



MADVIAND STATE DEDARTMENT OF HEALTH

tem₂21 ND

| Film 307 | MARYLAND STATE DE RESEARCH AND RECORDS, | PARTMENT OF HEA | LTH |
|-----------------------|--|-----------------------|------------------------|
| vision of STATISTICAL | RESEARCH AND RECORDS, | 301 W. PRESTON STREET | , BALTIMORE 1, MARYLAN |
| 13773 MED | DICAL EXAMINER'S | CERTIFICATE OF | DEATH 13749 |
| PPRES | 11 | | |

| . 1. | PLACE OF DEATH | 2. USUAL RESIDENCE (Where decessed lived, If Institution: Residence before edmission) |
|---------------|--|--|
| | e. COUNTY | a, STATE b, COUNTY |
|) - | b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | Maryland Carroll County |
| | write RURAL and give naerest town) | c. CITY OR TOWN (If outside corporete limits, write RURAL end give naerast town) |
| | Mt. Airv | X M+ A5 me |
| 1 | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS 0. IS RESIDENCE |
| | // | ON A FARM? |
| - | RFD # 2 | Md. R 2 |
| 3. | NAME OF First Middle DECEASED | Lest 4. DATE Month Dey Year |
| | (Type or print) DONALD PHILLIP HI | DEATH 10/ |
| 5. | | IDDLESTON December 20, 1761 Date of birth 19, age (in years lif under 1 year) if under 24 Hrs. |
| | | lest birthday) Months Days Hours Min |
| - | 110.10 | eb. 20, 1923 38 yrs. 10015 10015 |
| 10 d | e. USUAL OCCUPATION (Give kind of work one during most of working life, even if retired) | Y 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | Electronic Equipment Specialist | Texas USA |
| 13 | . FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| | ****** | |
|) | William Huddleston | Hettie Childer . |
| 1S | . WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I es, no, or unknown) (Ifyesgive werordates of service) | NFORMANT Address |
| | Yes WW 2 496-30-7581 | Mrs Nora Huddleston. Item 2 |
| - | 18. CAUSE OF DEATH [Enter only one cause per lina for (e), (b), end (c).] | Mrs Nora Huddleston, Item 2 |
| | PART I, DEATH WAS CAUSED BY | ONSET AND DEATH |
| | IMMEDIATE CAUSE (a) Gunshot wound of hea | ad and brain. |
| | 976 X DUE TO | |
| | Conditions, it ony, which) (b) | |
| | geve rise to immediate cause | |
| | (e), stating the underlying DUE TO | |
| | Cause lest. (c) | |
| O N | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| CERTIFICATION | | YES Y NO I |
| E | 20a, EXTERNAL CAUSE WAS 20b, DESCRIBE HOW INJURY OCCURED, (E | ntar nature of Injury In Part I or Part II of item 18.) |
| 18 | PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. | |
| | Shot through head. | |
| MEDICAL | 20c. TIME OF INJURY Month, Day, Yaar 20d. INJURY OCCURRED 20e. PLA: Hour e.m. While Not While factor | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) |
| Media | Trout et al. | Home Mt. Airy, Maryland |
| | 21. I certify that I took charge of the remains described above, he | |
| | | |
| | death resulted from: Natural causes, Accident, Suici | de X, Homicide , Underfermined menner/ |
| | 1/ 111 1 | CHIEF MEDICAL EXAMINER |
| | ACTUAL / / // | M.D. ASSISTANT MEDICAL EXAMINER X |
| | SIGNATURE JAMES J. Habel | DEPUTY MEDICAL EXAMINER |
| | EXAMINER'S NAME (Type) | |
| 20 | B. BURIAL, CREMATIO 22b. DATI THEREOF 22c. NAME OF CEMETERY OR | Address (Streat, city, lown, or county) 12/21/61 |
| 220 | REMOVAL (Spacify) | CREMATORY 22d. LOCATION (City, town, or country) (Stele) |
| | Burial Dec. 22.1961 Arlington I | National Ft. Myer. Va. |
| 23 | . FUNERAL DIRECTOR ADDRESS | 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE |
| | Clin & Mobsenth Damascus, | Md. DAREC 26'61 Civing S. Kraus |
| | , and the second of the second | DARRES & D. Commy A. Tumb |

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death on delay is necessary, please execute the certificate, writing the word "pending" in pending in lem 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examinar's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permy. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death. VS. AISME 5M 9/60

description of the second seco Dacabase . C. sepelused

13772

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH**

Reg. D&1. 76750

| | TO TO |
|--|--|
| 1. PLACE OF DEATH O. COUNTY Carroll MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Carroll |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest jown) Rural, Westminster c. LENGTH OF STAY IN 1b Life | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster |
| d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Westminster, Md. R. D. 1 | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES □ NO ■ |
| 3. NAME OF Charles First H. Middle Hum (Type or print) CHARLE . H H | Month Day Year OF DEATH December 21 1961 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years lost birthdoy) 63 yrs. Funder 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min. M |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Carpenter, All k: | ISTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Addison T. Humbert | 14. MOTHER'S MAIDEN NAME Sarah J. Halter |
| (Yes, no, or unknown) (If yes, give wor or dates of service) | rs. Mary Humbert, Westminster, Md. R.D.1 |
| Canditions, if any, which gave rise to immediate couse (a), stating the under-lying couse lost. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 20g. ACCIDENT WAS UNDERLYING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| | D. (Enter nature of injury in Part I or Port II of item 1B.) |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o. m. p. m. 19 While of work 19 of work 19 | ACE OF INJURY (Home, form, ctary, street, affice bldg., etc.) (City or town) (County) (State) |
| ACTUAL SIGNATURE Wylew Speiches PHYSICIAN'S NAME (Type) | appress (Street, city or fown, stote) DATE SIGNED M.D. Westwicks Les Mel 12/21/61 |
| 22c. NAME OF CEMETERY O Burial 22b. Date Thereof Burial 22c. NAME OF CEMETERY O Baust Church | |
| 23. SUMERAL DIRECTOR'S SIGNATURE ADDRESS Littlestown, | Pa. DATPEC 2 6 '61 246. REGISTRAR'S SIGNATURE Chrimy S. Huma |

Q E Q O VS A15 (4) 15M 9/5B

| | dominates stand | 512 | Andrea of the American |
|-----|------------------------------|------------|------------------------|
| | 1 (14 man 12 , 12 man 2) | | |
| 2. | | | |
| | | | |
| | and Louis . Hall | Ilean bear | Y daily, Q |
| | Texts alimn | | 12" private in the |
| 200 | telegram destrict the second | 25-49-07 | |
| * * | | | |
| | | | |
| | | | |
| | | | |

VS. ATSME BM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 20110 | | | |
|--|---------------------------------------|---|---|
| PLACE OF DEATH a. COUNTY Carroll | 11 | | nstitution: Rasidence bafore admission) |
| MARYLAND | a. STATE Mary: | b. coun | Washington |
| b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 | | If outsida corporata limits, write | |
| write RURAL and give nearest town) | H | | 2103-2 |
| Sykesville d. Name of Hospital or Institution (if not in hospital, give street address) | d. STREET ADDRESS | WIL | I e. IS RESIDENCE |
| | | | ON A FARM? |
| Springfield State Hospital | 1 26 E. Was | hington St. | YES NO X |
| DECEASED | Last | 4. DATE Month | Day Yaar |
| (Typa or print) Fleanor Florence John | son | December December | er 16 1961 |
| SEX [6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8 | B. DATE OF BIRTH | 9. AGE (In years last birthday) | |
| Female White WIDOWED TO DIVORCED | 6-21-17 | 50 yrs. | Months Days Hours Min. |
| 0a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTR | | 1) 0 | 12. CITIZEN OF WHAT COUNTRY |
| dona during most of working life, even if retirad) | N.Y. City | UH 12 | II C A |
| Enginerring Dep't Aircraft Mfc. | 14. MOTHER'S MAIDEN | | U.S.A. |
| | 14. MOTHER'S MAIDEN | NAME | |
| Richard H. Johnson | Edith John | nson | |
| 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 1 Yes, no, or unkown) (Ifyasgiva warordatasofservica) | INFORMANT | Address | |
| | ringfield St | ate Hospital | |
| 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c).] | I III I I I I I I I I I I I I I I I I | 900 1100p2 002 | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: Septicemia | | | ONSET AND DEATH |
| 1001 | | | 4 days |
| DUE TO | | | 7 70 1 |
| Conditions, if any, which gave rise to immediate causa | 5 | | 5-10 days |
| (a), stating the undarlying DUE TO | | | |
| causa last. (c) Lobar pneumonia | | | 5-14 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | OT RELATED TO THE TERMIN | NAL DISEASE CONDITION GIVE | |
| | | | PERFORMED? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | Enter natura of Injury in Par | t I or Part II of itam 18.) | 100 |
| PRIMARY or CONTRIBUTING CAUSE OF DEATH. | | | |
| | CE OF INJURY (Home, farn | n, ' 20f. (City or town) | (County) (Stata) |
| | lory, streat, offica bldg., etc. | | (County) (Sieta) |
| p.m. 19 at work at work | | | |
| 21. I certify that I took charge of the remains described above, he | eld an Autopsy 📈, | Inspection, Inquir | y , and in my opinion |
| death resulted from: Natural causes . Accident . Quic | ide , Homicide | , Undetermined ma | anner |
| 1 1 2 3 | CHIEF MEDICAL | EXAMINER | |
| ACTUAL GUILOS J. March | ASSISTANT MED | ICAL EXAMINER | DATE SIGNED |
| SIGNATURE | M.D. ASSISTANT MED | | 12/01 |
| | DEDLITY MEDICAL | | |
| TRAMPER'S James T. Marsh | DEPUTY MEDICA | 42 | 110/61 |
| EXAMPLE'S James T. Marsh 2. BURAL CHMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OF | Addrass (Streat, | city, town, or county) 22d. LOCATION (City, town, | or country) (State) |
| NAME (Type) O CHIES 1. HELTSIT 28. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OF REMOVAL (Specify) | Addrass (Streat, | city, town, or county) 22d. LOCATION (City, town, | |
| NAME (1700) O CHINGS 1. FIGURE 1 | Addrass (Streat, or CREMATORY | city, town, or county) | Maryland |
| NAME (Types) 0 diffes 1. Hell SIT 22 BUILDAL CHMATION 22b. DATE THEREOF 22c. NAME OF CEMETERY OF REMOVAL (Specify) But 131 Dec 20 1961 Rose Hill | Addrass (Streat, or CREMATORY | city, town, or county) 22d. LOCATION (City, town, Haperstown 'D 8Y REGISTRAR 24b. REGI | Maryland |

MAIN IN HE SHEW THE SHEW THE SHEADY SAN THE SECOND STREET . in the first of the state of monarios . P francis THE THE STREET WASHINGTON TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician.

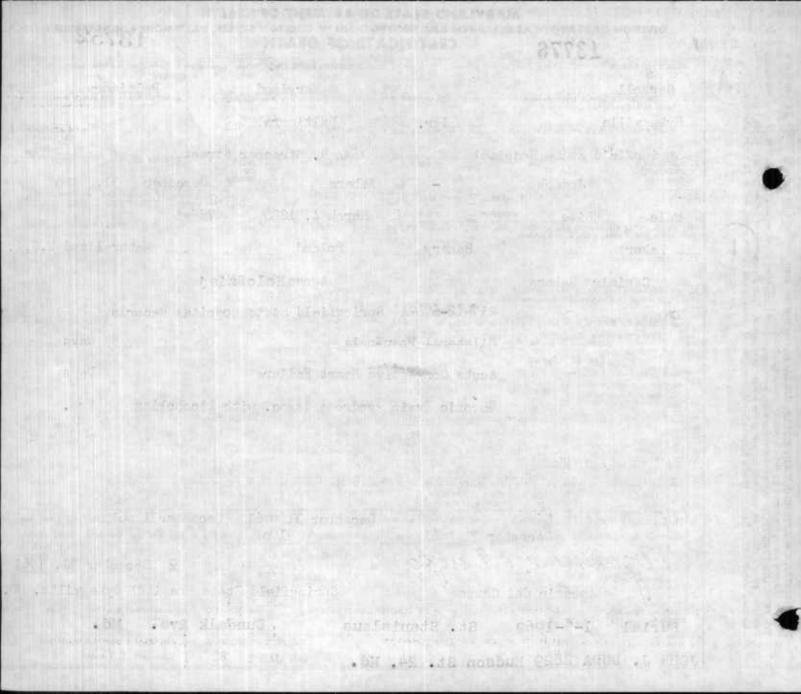
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and control tilled in by the tuneral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1277C CERTIFICATE OF DEATH 13776

| 1. PLACE OF DEATH e. COUNTY | 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before admission) |
|--|--|
| | a. STATE b. COUNTY |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1 | Mar Araug Serrormore |
| Sykesville lvr. | Baltimore 3 VOI-4 |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give sifeet eddress) | d. STREET ADDRESS o. IS RESIDENCE ON A FARM? |
| Springfield State Hospital NAME OF STATE OF STA | 644 S. Streeper Street YES NO W |
| 3. NAME OF First Middle DECEASED | Last 4. DATE Month Day Yeer OF |
| (Type or print) Joseph - | Kabara December 31, 1%1 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| Male White WIDOWED DIVORCED | March 4, 1886 75 yrs. Months Deys Hours Min. |
| | STRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| Baker Bakery | Poland Naturalized U.S.A |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| A | A seed on the seed of |
| Casimir Kabara 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 | Agnes Kolodzie j |
| (Yes, no, or unkown) (Ifyesgive weror detesofservice) | , MATORITAL AUGUS |
| No 219-12-6762A | Springfield State Hospital Records |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Bilateral Pnew | |
| 3 4 11 | monta Daya |
| SO4X DUE TO | |
| Conditions, if eny, which the Acute Congesti | ve Heart Failure Days |
| geve rise to immediate cause (e), stating the underlying | |
| | Syndrome Assoc. with Alcoholism Yrs. |
| | |
| CATIO | PERFORMED? YES NO TO |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 206. ACCIDENT WAS UNDERLYING COP CONTRIBUTING CAUSE OF DEATH U | RED. (Enter neture of Injury in Pert I or Pert II of item 18.) |
| 古 Hour e.m. WhileNot While | PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Steta) (ectory, street, office bldg., etc.) |
| | |
| | mDecember31., 1961, to.December31, 1961., that (I) (we) last |
| saw the deceased alive on December 311961., and the | hat death occured at $10p$ M, from the causes and on the date stated above. |
| 220 Caristin del Campo | ATTENDING MED. STAFF SIGNED PHYS. December 31, 196 |
| 236 PHYSICIAN'S | 22d. ADDRESS |
| Agustin del Campo | Springfield State Hospital Sykesville, M |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 1-5-1962 23c. NAME OF CEMETER St. Stanis | |
| | |
| 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE |
| JOHN J. DUDA 2829 Hudson St. 24, | Md. DATE JAN 8 62 Cuther S. Thous |

VR A15 (4)



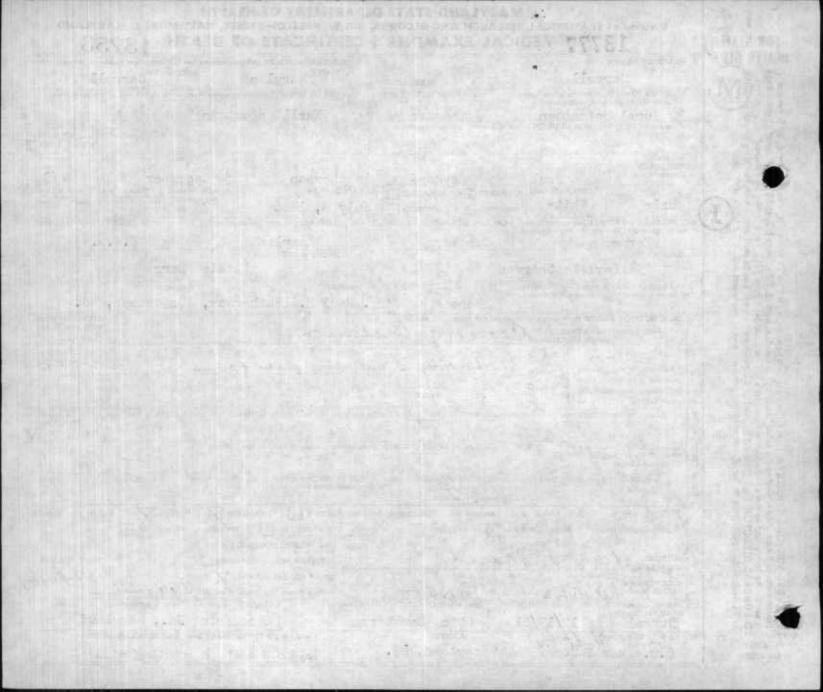
FOR STATE TO SEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death my delity is necessary, please execute the certificate, writing the word "pending" in pendi in Item 18. Give Pages 1, 2, and 3. It tuneral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your filler. TO FUNERAL DIRECTOR: Page 3 should be used as a burish-transit permit. File pages 1 and 2 with the State Board of Fleath, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13777 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 42753 13777

| | . PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) |
|-----|---|-----------|--|
| 1 | | LAND | *. STATE Maryland b. COUNTY Carroll . |
| / | b. CITY OR TOWN (if outside corporeta limits, write RURAL end give nearest town) | AY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| | Rural Uniontown Hours | 046.0 | X KWEXX Uniontown |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street edds | ress) | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\sum \) NO \(\sum \) |
| 1 | NAME OF First Middle DECEASED | | Last 4. DATE Month Day Yeer OF |
| | (Type or print) Paul Raymond | | Leatherman December 14 1961 |
| 1 | 6. COLOR OR RACE 7. MARRIED X NEVER MARRIE | ED 8 | DATE OF BIRTH 9. AGE (In yeers IF UNDER 1 YEAR IF UNDER 24 HRS. last birthdey) Months Days Hours Min. |
| LJ | Male White WIDOWED DIVORCE | D 🔲 | July 5, 1886 75 yrs. Months Days Hours Min. |
| 4 | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | RINDUSTR | Y 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY |
| | Farmer Own Farm | | Maryland U.S.A. |
| 1 | 3. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME |
| | Levi Leatherman | 130 | Lizzie Derr |
| | 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY N (Yas, no, or unkown) (Ifyesgivewerordetesofservice) | IO. 17. I | NFORMANT Address |
| | No None | Mrs | . Paul R. Leatherman, Uniontown, Md. |
| | 18. CAUSE OF DEATH [Enter only one cause per fine for (a), (b), end (c | c).] | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | ace | luxur Sur Short and Death |
| | 420,1 DUE TO: A | ~ | |
| | Conditions, if any, which) (b) Corons | art | eny decise year. |
| 1 | gave rise to immediate ceuse | | |
| | (a), steting the underlying cause lest. | | |
| | (6) | TH BUT NO | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY |
| | | | PERFORMED? |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEAT 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | CURED. (E | nter natura of Injury in Pert I or Pert II of Item 18.) |
| - 1 | | 11/2 | |
| | 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED While Not While et work at work | | CE OF INJURY (Home, ferm, 20f. (City or town) (County) (State) ry, street, office bldg., etc.) |
| | 21. I certify that I took charge of the remains described at | bove, he | ld an Autopsy , Inspection Inquiry , and in my opinion |
| | death resulted from: Natural causes X, Accident | , Suici | de , Homicide , Undetermined manner |
| | 1 1 40 | | CHIEF MEDICAL EXAMINER |
| 1 | ACTUAL LUCES J. March | | ASSISTANT MEDICAL EXAMINER TO DATE SIGNED |
| 1 | SIGNAPOR | | DEPUTY MEDICAL EXAMINER 12/14/ |
| 1 | NAME PROSTAMES / MARSH | + | Address (Street, city, town, or county) |
| 1 | 20. IULIAI, CREMATION, 22b. DATE THEREOF 22c., NAME OF CEN | AETERY OR | CREMATORY 22d. LOCATION (City, town, or country) (State) |
| 1 | Burial 12/17/61 Utica Ce | meter | y Frederick Co., Maryland |
| | 23. FUNERAL DIRECTOR of Skiles ADDRESS | - 11 | 24e. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE |
| | C.O. Fuss & Son Taneytown, | Md. | DATDEC 1 8 '61 Orthur & Kraus |
| I- | | | |

VS. A15ME 5M 7/59

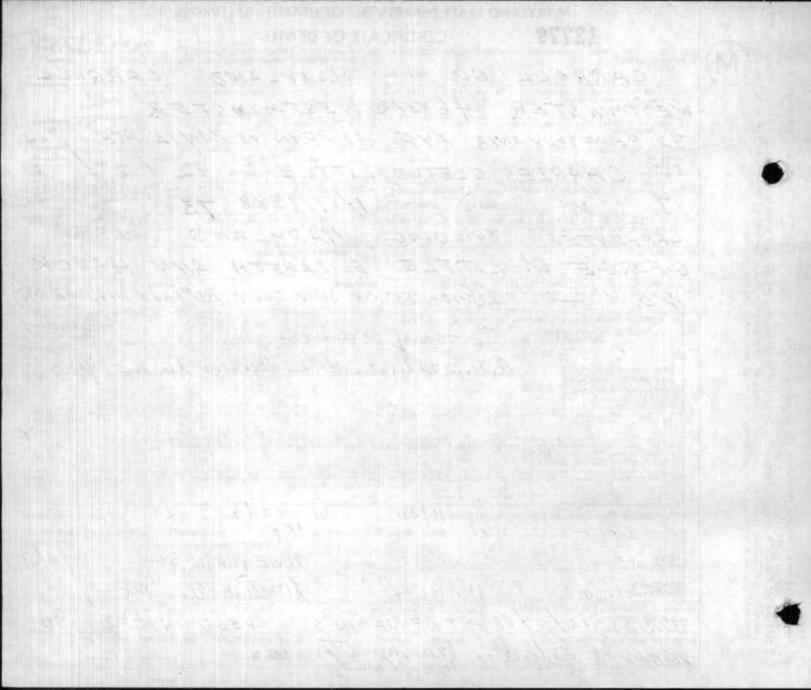


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| | * | 13778 | CERTIFIC | ATE OF DEATH | | Reg. Dist. Ng. 2751 | |
|------------------|--|---|---|--|-------------------------------------|---|-----|
| a. | ACE OF DEATH | roll | MARYLAND | manil | end b. COUNT | Carroff | |
| 3 | *URAL and give ne | f autside corporate limits, v parest tawn) AL (If not in hospital, give | 1 874m. | d. STREET ADDRESS | utside corporate limits, write | RURAL and give nearest town) e. IS RESIDENCE ON A FARM | |
| DE | AME OF ECEASED ype or print) | SARAH | Middle AMANDA A | EISTER | 4. DATE MOF DEATH | anth Day Year | ב |
| 5.5 | male | white wi | MARRIED NEVER MARRIED DOWED DIVORCED DIVORCED | B. DATE OF BIRTH Set, 13, 18 | 74 9. AGE (In year last birthday yr | rs IF UNDER 1 YEAR IF UNDER 24 H Manths Days Haurs Min | |
| h | ATHER'S NAME | ing life, even if refired) | 106. KIND OF BUSINESS OR IND | 14. MOTHER'S MAIDEN N | Cs.ml. | 12. CITIZEN OF WHAT COUNTI | Y ? |
| 15. W (Yes, n | /AS DECEASED EVE | R IN U. S. ARMED FORCES' | 16. SOCIAL SECURITY NO. | INFORMANT WAS SHOWN | Leiste & | dofess | 7 |
| T | | TH [Enter only one cause TH WAS CAUSED BY: IMMEDIATE CAUSE (a) | per line far (a), (b), and (c).] Longestive A | out Factur | - | INTERVAL BETWEEN OMSET AND DEATH 2. days | |
| | Canditians, if an gave rise to it cause (a), stating lying cause last. | mmediate (| Arterio securitio | Cordis Vacculor | disease | years | |
| CATION | | SER SIGNIFICANT CONDITI | ONS <u>CONTRIBUTING TO DEATH</u> BU | IT NOT RELATED TO THE TERMIN | nal disease condition g | GIVEN IN PART 1(a) 19. WAS AUTOPPERFORMED? YES NO | |
| 0 1 | IF EITHER, NOTIFY | CAUSE OF DEATH MEDICAL EXAMINER) | . DESCRIBE HOW INJURY OCCURE | | | | |
| MEDICA | Oc. TIME OF INJUR Haur a. m. p. m. | 10 | 20d. INJURY OCCURRED 20e. I | PLACE OF INJURY (Hame, farm, actary, street, affice bldg., etc.) | | (Caunty) (Sta | |
| 0 | F. ST. W. C. | at 1 attended the de N 19 | | | | Efthat I last saw the deceas and an the date stated aba- in, state) DATE SIGN 12120/ | ve. |
| l l | PHYSICIAN'S TA | | ARSH | Westun | | | - |
| 13 | BURIAL, CREMATIO REMOVAL (Specify) | 12/23/6 | 22c. MAME OF CEMETERY | wel centley | 22d. LOCATION (City, town | transter med | |
| 23. FC | 2 - 2 - 5 | mes & | Westminster | DATEDEC | | orthur S. Kraus | |

The state of the s Walter See See

| | MAKYLAND STATE DEI | PARIMENT OF HEALTH | BALIIMORE, 18 | |
|-----------|--|--|---|--|
| | 13779 CER | TIFICATE OF DEATH | Reg. Dist. No. | 3755 |
| 1. | 1. PLACE OF DEATH O. COUNTY CARROLL CO. M | 2. USUAL RESIDENCE (Where on STATE of STATE) | deceased lived. If institution: Residence before AND b. COUNTY CARR | re admission) |
| 1 | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER 46 Y | 4-10-11- | de corporate limits, write RURAL and give nea VNSTER 27 | rest town) |
| | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 32 PENN SYL VANIA AV | E. 32 PENNSI | 484.1 | ON A FARM? YES NO |
| 3. | 3. NAME OF DECEASED (Type or print) CHARLES CLET | 4 ' | DATE OF DEATH /2 Month / 2 Do | Year 61 |
| 5. | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MA WIDOWED DIVO | RRIED B. DATE OF BIRTH | 8 9. AGE (In years If UNDER I YEAR Months Days | TF UNDER 24 HRS. Hours Min. |
| 10 | 10a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINES during most of working life, even if retired) CARPENTER BUILDII | | AND 12. CITIZEN OF U. S. | WHAT COUNTRY? |
| 13. | 13. FATHER'S NAME GEORGE W. LITTL | E ELIZA BET | | UCK |
| 15. (Y | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or upknown) (If yes, give war or dates of service) 215-10-1/ | | OF RD* NEW WINL | SOR MI |
| | 1B. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acres | ONS | RVAL BETWEEN ET AND DEATH |
| | Conditions, if any, which) (b) Arterio Se | | seular disease " | years. |
| | gove rise to immediate couse (o), stating the <u>under-lying</u> cause lost. | REAL AND POR | | |
| CATION | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO | DEATH BUT NOT RELATED TO THE TERMINAL | DISEASE CONDITION GIVEN IN PART 1(a) | 9. WAS AUTOPSY PERFORMED? YES NO S |
| CERTIFI | © 200. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJUR OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | Y OCCURRED. (Enter noture of injury in Part | l or Port II of item 1B.) | |
| MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour o. m. While Not while of work of work of work | 20e. PLACE OF INJURY (Home, farm, 2 foctory, street, office bldg., etc.) | (County) | (Stote) |
| | 21. I certify that I attended the deceased fram.// | 30 , 1961, to 12 hat death accurred at 10 PM, | 12, 19 4, that I last saw | |
| | actual James 2 March | | PRESS (Street, city ar tawn, state) | DATE SIGNED |
| | PHYSICIAN'S TAMES TMARS | H Project | Tura te - "Mil | |
| 22 | 220. BURIAL, CREMATION, 276. DATE THEREOF, 22c. NAME OF C | EMETERY OR CREMATORY 22d | LOCATION (City, town, or county) | (Stote) |
| 23. | 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | tmins to DATE DATE DATE DATE DATE DATE DATE DATE | | |



15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| DION | OF STATISTICAL | RESEARCH AND RECORDS, | 301 W. PRESTON |
|------|----------------|-----------------------|----------------|
| | 13780 | CERTIFICATE | OF DEATH |
| | 20000 | | |

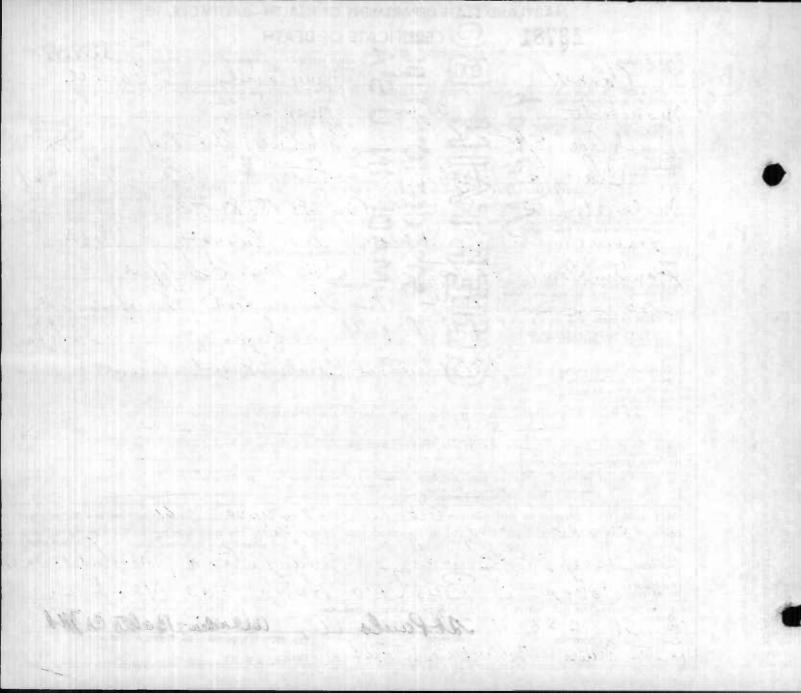
13756

| 1. | 1. PLACE OF DEATH | UAL RESIDENCE (Where deceased lived, If Institution, Res | sidence before edmission) |
|---------------|--|---|--------------------------------|
| | O. COUNTY ARROLL MARYLAND O. S | STATEM ARYLAND COUNTY | ARROLL |
| | b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 1b c. C | CITY OR TOWN (If outside corporete limits, write RURAL and | give nearest town) |
| K | RUKAL NEW WINDSOR 20 FEABXR | URAL - NEW WINDS | OR, MD. |
| | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress) | STREET ADDRESS | e. IS RESIDENCE |
| | CARROLL COUNTY GENERAL HOSPITAL I | RD# I NEW WINDSON | YES NO |
| 3. | 3. NAME OF First Middle DECEASED ; / | Last 4. DATE Month | Day Year |
| _ | (Type or print) HARRY W. L | ITTLE DEATH DEC. 4 | 196/ |
| ٥. | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATECT | OF BIRTH 9. AGE (In years IF UNDER 1 YI) 1 | |
| 10 | WIDOWED DIVORCED / / 2 | 6/18/1 84 yrs. | |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BI | IRTHPLACE (County & State, or foreign country) 12. CITIZI | EN OF WHAT COUNTRY? |
| 13. | CAMPENTEN | THER'S MAIDEN NAME | 3.4, |
| | JACOB H. LITTLE M. | ARCARET DUFFT | |
| 15. | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORM | Address Address | |
| (Y) | (Yes, no, or unkown) (Ifyesgivewarordatesofservice) won E MRS.1 | YARGARET WESTFALL | |
| | 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) U.S. C. Values | e à desonspenstion | ONSET AND DEATH |
| | DUE TO | - Carte faire and | 1000 |
| | Committee to the committee of the commit | V | |
| | gave rise to immediate cause (b) | | |
| | (e), stating the underlying DUE TO | | |
| | cause lest. (c) | | |
| Z O | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATE | ED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 | (a) 19. WAS AUTOPSY PERFORMED? |
| ζ, | Juanition - | | YES NO NO |
| CEKILLICATION | 208. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURED. (Enter no or CONTRIBUTING CAUSE OF DEATH | atura of injury in Part I or Part II of item 18.) | |
| | | | |
| MEDICAL | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF IN | UURY (Home, farm, 20f. (City or town) (County t, office bldg., etc.) | y) (State) |
| WED | Hour a.m. While Not While factory, street et work et work | | |
| | 21. I certify that (I) (this hospital) attended the deceased from Max. | 30 196/10 Dec 4 196 | that (I) (we) last |
| | | occured af. P.M. from the causes and on the | ., ., ., |
| | 22a SIGNATURE 4 GA | | 22b. DATE |
| | M.D. PHI | TENDING MED. STAFF | SIGNED |
| | 122c. HKYSIGIAN'S 22d | 1. ADDRESS | |
| | INTES 1. IMARSTI | Walnutter no | |
| 23 | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREM | 1-1- DE 1-0 210 11 1 | (State) |
| - | | EMETERY DEEK PARK, N | 0) |
| 24 | 24 FUNERAL DIRECTOR'S SIGNATURE 11.00 DDRESS | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SH | |
| | James M. Daller h. Westmine | DATOFC 7 '61 Walter & the | att A |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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| 1 | death. Page 4 may be retained by the hospital or attending physician. | TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and control of the funeral | eta | be filed with the State Dept, of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. | |
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 13758 12700

| 10104 | | | 10100 |
|---|--|---|--|
| LACE OF DEATH COUNTY | | CE (Where deceased lived, If Ir | stitution; Residence before edmission) |
| MARYLAND MARYLAND | a. STATE | b. COUNT | Manter |
| b. CITY OR TOWN (if outside corporata limits, c. LENGTH OF STAY IN 1b | Mary | Land If outside corporate limits, write | PURAL - d - lus - (- a d - lus - a d - lu |
| write RURAL and give nearest town) | c. citi ok towin | it outside corporate timns, write | KOKAL end give neeresi lown, |
| Rural) Sykesville, Md. 4y. 8m. 18d. | Rocky | ille | 15 10 - 21 |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give streat address) | d. STREET ADDRESS | | IS RESIDENCE |
| Springfield State Hospital | 721 B | rent Road | YES NO X |
| 3. NAME OF First Middle DECEASED | Last | 4. DATE Month | Day Year |
| (Type or print) George Lewis Lut | z. Sr. | DEATH 12 | 3 19 61 |
| 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED B | . DATE OF BIRTH | 9. AGE (In years | |
| male white widowed Divorced | 1-24-1881 | last birthday) | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work 1 10b. KIND OF BUSINESS OR INDUSTR | | 1 00 | 12. CITIZEN OF WHAT COUNTRY |
| dona during most of working lifa, evan if retired) | II. BIRTIFEACE (COU | ily & Siela, or foreign country) | 12. CHIZZA OF WHAT COOKING |
| | Marylar | nd | USA |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN | | |
| Tank a Tak | | (1.) | |
| LOWIS BUTZ 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 1 | Sally | Mispiva | n) |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. I (Yes, no, or unkown) (Ifyesgivewarordatesofservice) | NFORMANT | Address | |
| unknown unknown unknown | Hospital Red | orde | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] | HODDI OUT THE | 201 (18 | INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: Coronary Occlusion | | | ONSET AND DEATH |
| IMMEDIATE CAUSE (a) OUT OTTALLY OCCIUSION | 1 | | 5 min. |
| DUE TO | | | |
| Conditions, if any, which \ Arteriosclerosis h | eart disease | 9 | vears |
| geve rise to Immediate ceusa | | | |
| (a), stelling the underlying | anal amania | | |
| causa last. (c) Generalized arteri | | | years |
| part II. Other significant conditions contributing to death but no Chronic Brain Syndrome associated with psychotic reaction. | cerebral ar | rteriosclerosis | |
| DSYCHOTIC reaction 200. ACCIDENT WAS UNDERLYING Zob. DESCRIBE HOW INJURY OCCURED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | . (Enter neture of injury in | Pert I or Part II of item 1B.) | |
| | OF OF INTERNATOR | 1001 | (6)-1) |
| | CE OF INJURY (Home, ferr ory, street, office bldg., atc | | (County) (State) |
| et work at work at work | | | |
| 21. I certify that (I) (this hospital) attended the deceased from. | Sontombon | 1060 to Dog 2 | 167 that (1) (wa) lac |
| | the state of the s | h | |
| saw the deceased alive onDec | death occured ak | DLM, from the causes a | |
| 22e. SIGNATURE | ATTENDING | MED. STAFF | 22b. DATE |
| Jares tol eleche N | D. PHYS. | DIRECTOR PHYS. | 12-3-1961 |
| 22c. PHYSICIAN | 22d. ADDRESS | | |
| NAME (Type Yasuo Takahashi, M.D | | | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY | OR CREMATORY | 234 LOCATION City tow | n or county) . (Stata) |
| REMIDVAL (Specify) | | 10 . +0 | A. NIA |
| Buried 12/6/6/ DT auch |) | 10ml Aller | Jes Ma |
| 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 25a. RE | C'D BY REGISTRAR (356. REG | ISTRAR'S SIGNATURE |
| M. Min. 12 16 Mari Bar will | VO DO DATE | DEC 8 '61 a | rilling S. Kraus |
| Chillen dy 11 Charles Inches | CHILL DAIR | 1 0 0 · · · | , A. , V. |

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 13783

13759

| 8 | 1, [| PLACE OF DEATH | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o.STATE b. COUNTY | | | | |
|---|-------------|---|---|--|--|--|--|
| | | Wellsall MARYLAND | Mangleund . com Cunnil | | | | |
| | ŀ | c. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b RURAL and give negrest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | |
| | U | mon Bidge (line) / Mouth | X Munahester | | | | |
| | | J. NAME OF HOSPITAL (If not in hospital, give street address) | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? | | | | |
| | 2 | Horton Boarding Hours | YES NO X | | | | |
| | 3. 1 | NAME OF First Middle | Last 4. DATE Month Day Year | | | | |
| | | Type or print) MELCHOIR - MA | 9 EMORE DEATH 12 18 1961 | | | | |
| | S. S | EX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost, birthdoy) Months Days Hours Min | | | | |
| | | M WIDOWED DIVORCED | Left 3-187/ 90 yrs. | | | | |
| | 10a | USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, even if retired) | STRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY | | | | |
| | | noul | Mullend WSA | | | | |
| Н | 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | |
| Н | - | Tlorgh H Maseurel | Mary Bull | | | | |
| | 1S. (Yes | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN. no, or unknown) If yes, give wor or dates of service) | FORMANT Address | | | | |
| | | 120 100 111 | LA Elean Tribuyo: Mellafrella MA | | | | |
| | | 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | INTERVAL BETWEEN | | | | |
| | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral | Branchamen moria ONSET AND DEATH | | | | |
| | | 491X DUE TO | | | | | |
| | | Conditions, if ony, which) (b) | | | | | |
| | | gove rise to immediate | | | | | |
|) | | lying couse lost. | | | | | |
| И | Z | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY | | | | |
| | CATION | O arteriscleratic Cardio vasa | lar disease Chronic Pycloroph YES NO | | | | |
| | IFF | 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18!) | | | | | |
| | CER | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| | CAL | 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLA | ACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stote) | | | | |
| | MEDICAL | Hour o. m. While Not while for p. m. 19 of work of work | tory, street, office bldg., etc.) | | | | |
| | < | | D = 3 20(1. D. 10 20(1.4.1) | | | | |
| | | 21. I certify that (I) (this haspital) attended the deceased fram. Dec. 3. 1961, ta Dec. 18. 1961, that (I) (we) last saw the deceased alive an Dec. 17. 1961, and that death accurred at 0.50 M, fram the causes and an the date stated above. | | | | | |
| | | saw the deceased alive and that d | leath accurred at V—M, fram the causes and an the date stated above. | | | | |
| | | $()$ \mathcal{U} | ATTENDINO MED. STAFF | | | | |
| | | 22c. PHYSICIAN'S | M.D. PHYS. DIRECTOR PHYS. 12-18/6/ | | | | |
| | | NAME (Type) J.H. CARICOFE | Union Bridge MARYLAND | | | | |
| | 230 | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY O | Da la alla alla alla alla alla alla all | | | | |
| | 4 | FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | | | | |
| | VI | After Elice Heurstean | 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE CALLING & KLAUS | | | | |
| 9 | - | | · · · · · · · · · · · · · · · · · · · | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 13760

| 7240 | 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence bafore edmission) | | | | |
|------|--|---|--|--|--|--|
| 1 | Carroll MARYLAND | o. STATE Maryland Montgomery | | | | |
| | b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | |
| | write RURAL end give neerest town) Sykesville 3yrs.3mos.3dat | Bethesda 1548-2 | | | | |
| 1 | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) | d. STREET ADDRESS e. IS RESIDENCE | | | | |
| 2 | Springfield State Hospital | 4970 Battery Lane | | | | |
| | 3. NAME OF First Middle DECEASED | Last 4. DATE Month Dey Yeer | | | | |
| | (Type or print) Walker | Mayfield December 6, 1961 | | | | |
| | 7. MARKIES THE TER MARKES | DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. | | | | |
| | Male White WIDOWED ADIVORCED | November 28, 1870 91 yrs. Months Doys Hours Min. | | | | |
| | 10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| | Unknown Minister Methods + Hand | Illinois U.S.A. | | | | |
| | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | |
| | Unlarown (May) Mayfill | Unknown/leaks trulist | | | | |
| | 15. WAS DECEASED EYER IN U.S. ARMED TORCEST 198. SOUTAL SECURITY NO. 17. II | NFORMANT Address | | | | |
| | (Yes, no or unkown) (Ifyasg ve war ar dates of service) Sr | oringfield Hospital Records | | | | |
| | 18. CAUSE OF DEATH [Enter only one ceuse per lina for (a), (b), end (c).] | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 8 | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right lower lobe to | oneumonia Days | | | | |
| | The Due to | | | | | |
| | Conditions, if any, which (b) | | | | | |
| | gava risa to immadiate ceusa | | | | | |
| Н | (a), stating the underlying | | | | | |
| н | (c) | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY | | | | |
| | C.B.S. assoc.with senile brain disease 20. Accident was underlying 20b. describe how injury occured. OR CONTRIBUTING CAUSE OF DEATH If EITHER, NOTIFY MEDICAL EXAMINER! | without qualifying phrase. PERFORMED? YES NO PA | | | | |
| | 2De. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH | | | | | |
| | | | | | | |
| | | CE OF INJURY (Home, ferm, 20f. (City or town) (County) (State) | | | | |
| | Hour a.m. While Not While tacks p,m. 19 et work at work | 1 | | | | |
| Н | 21. I certify that (I) (this hospital) attended the deceased from | September 2, 1958, December 6, 1961, that (1) (we) last | | | | |
| | saw the deceased alive on December 6, 1961, and that death occurred 7:45PM from the causes and on the date stated above. | | | | | |
| | 22e. SUGNATURE - 1 1 1 | | | | | |
| | Closusters del Campo M | D. ATTENDING MED. STAFF PHYS. TO 12/7/61 | | | | |
| | 22c. PHYSICIAN'S | 22d. ADDRESS | | | | |
| 3 | NAME (Type) Agustin delCampo, M.D. | Springfield Hospital, Sykesville, Md. | | | | |
| | 238. BURIAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY | DR CREMATORY 23d. LOCATION (City_town_or county) | | | | |
| | REMOVAL (Specify) 12-10-61 Marchael | L Stronwell, Ville | | | | |
| | 24 FUNERAL DIRECTOR'S-SIGNATURE /// ADDRESS | 258. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE | | | | |
| | Culled IV Stally (Fertinally) | Med - DATE DEC 1 3 '61 Quilles & House | | | | |
| 1 | | (| | | | |

18/28/2 money amenda and and and and to DESERT -- -- INDE * * * The same will be the store of the same of the state of the s Marches St. William Controlled " Mark is the state of the

stely filled in by the funeral pers. Pages 1 and 2 should ited within 24 hours after Pages HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be sain. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and director, page 3 should be detached for use as the burial-transit permit. Then please remove sarbo be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with VR A15 (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13785 CERTIFICATE OF DEATH

| 1. PLACE OF DEATH a. COUNTY | | NCE (Where daceased lived, If institutions | Residence before admission) | | |
|--|--|---|--|--|--|
| Carroll MARYLAND | *. SIATE Marylan | d Allegar | nv / | | |
| b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | | (If outside corporete limits, write RURAL an | - U | | |
| write RURAL and give nearest town) | Danwar | 1 Cuanatava | Alv.7 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRES | ly Cresaptown, | a. IS RESIDENCE | | |
| | | | ON A FARM? | | |
| Springfield State Hospital | Winche | ester Rd. | YES NO A | | |
| 3. NAME OF First Middle DECEASED | Lasi | 4. DATE Month | Dey Year | | |
| (Type or print) Elizabeth Mary | McKenzie | December December | 28 19 61 | | |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | . DATE OF BIRTH | 9. AGE (In years IF UNDER | YEAR IF UNDER 24 HRS. | | |
| Female White WIDOWED X DIVORCED | 6-13-91 | last birthday) Months | Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTR | | | IZEN OF WHAT COUNTRY? | | |
| dona during most of working lifa, even if retirad) | | | | | |
| Housewife Own home | Marylar | | U.S.A. | | |
| IS. PATHER'S NAME | 14. MOTHER'S MAIDE | NAME | | | |
| Julius Gratenstein | Mary | Marty | | | |
| | NFORMANT | Address | | | |
| | ninafiald S | State Hospital Recor | de | | |
| No None ST | of Tugitera c | da de mospituat necor | I INTERVAL BETWEEN | | |
| PART I. DEATH WAS CAUSED BY: | | | ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) Myocardial infar | ction | | Hours | | |
| DUE TO | | | 1 1 1 1 1 1 | | |
| Conditions, if any, which (b) | | | | | |
| gave rise to immediate ceusa (a), stating the underlying DUE TO | | | | | |
| cause lest. (c) | | | | | |
| | T RELATED TO THE TERM | INAL DISEASE CONDITION GIVEN IN PART | T 1(e) 19. WAS AUTOPSY | | |
| Schizophrenic reaction, catatonic type | • | | PERFORMED? | | |
| A COURT WAS THE PROPERTY OF A COURT WAS THE PROPERTY WAS THE PROPERTY OF A COURT WAS THE PROPERTY WAS THE PROPERT | | | | | |
| | | | YES NO | | |
| 206. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURED. OR CONTRIBUTING CAUSE OF DEATH | , (Enter neture of injury in | Pert I or Part II of item 18.) | LES NO T | | |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | . (Enter neture of injury is | n Pert I or Part II of item 18.) | TES NO | | |
| | CE OF INJURY (Home, fe. | rm, † 20f. (City or town) (Cou | | | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA Hour a.m. Whila hot whila | | rm, † 20f. (City or town) (Cou | | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA Hour a.m. Whila at work at work at work | CE OF INJURY (Home, fe. | rm, 20f. (City or town) (Cou | inty) (State) | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA Whila Not Whila at work 21. I certify that (I) (this hospital) atlended the deceased from | CE OF INJURY (Home, feory, street, office bldg., al | 20f. (City or town) (Coulo.) 19, to12-28, 19 | (Stete) | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA Hour a.m. Whila at work at work at work | CE OF INJURY (Home, feory, street, office bldg., al | 20f. (City or town) (Coulo.) 19, to12-28, 19 | (Stete) | | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA While at work 19 at work 21. I certify that (I) (this hospital) attended the deceased from 1961, and that | CE OF INJURY (Home, feory, street, office bldg., al | 19, to 12-28, 19. LO: AO apm the causes and on | (State) 61, that (I) (we) last the date stated above 22b. DATE | | |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLA facts at work 19 at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on | CE OF INJURY (Home, fe, ory, street, office bldg., all ory, street, ory, street, ory, street, or | 20f. (City or town) (Coulo.) 19, to12-28, 19 | (State) 61, that (I) (we) last the date stated above. | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA Hour a.m., p.m. 19 While at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on | CE OF INJURY (Home, fe, ory, street, office bldg., all ory, street, ory, street, ory, street, or | 19, to12=28 | (State) 61, that (I) (we) last the date stated above 22b. DATE | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA While Not While at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on | CE OF INJURY (Home, feed only, street, office bldg., all only street, office bldg. | 19, to12=28 | (Stete) 61, that (I) (we) last the date stated above 22b. DATE SIGNED 12-28-61 | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA While Not While at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on | CE OF INJURY (Home, fecory, street, office bidg., electrons, street, office bidg. | 19, to | (State) 61, that (I) (we) last the date stated above. 22b. DATE SIGNED 12-28-61 | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA While at work 19 at w | CE OF INJURY (Home, fecory, street, office bidg., all and all all all all all all all all all al | 20f. (City or town) (Country) 19, to | (State) 61, that (I) (we) last the date stated above. 22b. DATE SIGNED 12-28-61 Sykesville, No. (State) | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 4 facts work 19 work | CE OF INJURY (Home, fe. ory, street, office bldg., all all all all all all all all all al | 20f. (City or town) (Country) 19, to | (State) 61, that (I) (we) last the date stated above. 22b. DATE SIGNED 12-28-61 Sykesville, No. (State) | | |
| 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA While at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on | CE OF INJURY (Home, feory, street, office bldg., all all all all all all all all all al | 20f. (City or town) (Country) 19, to12-28, 19. 21, to12-28, 19. 22, to | (State) 61, that (I) (we) last the date stated above. 22b. DATE SIGNED 12-28-61 Sykesville, M. (State) | | |

No. of the Contact A DESCRIPTION OF THE PROPERTY .ou tosto ould . west think on a lower although the And Andrews of the Claim of the Community of the Communit Charles La Coorge Commertence, No.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | |
|--|---|--|--|--|--|--|
| | 13786 CERTIFICA | TE OF DEATH | | | | |
| 1 | 1. PLACE OF DEATH O. COUNTY MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY ARROLL ARROLL | | | | |
| / | b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | |
| | d. NAME OF HOSPITAL (If nat in haspital, give street address) OR INSTITUTION | d. STREET ADDRESS o. IS RESIDENCE ON A FARM? | | | | |
| | 36 MAIN ST 3. NAME OF First Middle | 36 MAIN ST. YES NO | | | | |
| | (Type or print) LIZZIE MAY ML | ETCALFE DEATH DE 0 19 196 | | | | |
| | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED | B. DATE OF BIRTH 18 Nov. 18 73 9. AGE (In yeors IF UNDER 1 YEAR IF UNDER 24 HRS If UNDER 1 YEAR IF UNDER 24 HRS Manths Doys Hours Min. | | | | |
| | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER AT HOME | MARYLAND U.S. | | | | |
| | REUBEN SAVLER | MARGARET WRIGHT | | | | |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN (Yes, no. or unknown) (If yes, give war or dates of service) | FRANK WETHALEF LANDA BRINGEN | | | | |
| | 18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] | 7 INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave rise to immediate cause (a), stating the <u>under-lying</u> cause last. (c) | yonds minning | | | | |
| | | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \(\subseteq \text{NO} \) | | | | |
| | | D. (Enter noture of injury in Port I ar Port II of item 18.) | | | | |
| | 20c. TIME OF INJURY Manth, Day, Yeor 20d. INJURY OCCURRED for the p. m. 19 at work at work | ACE OF INJURY (Home, form, 20f. (City or town) (County) (State ctory, street, office bldg., etc.) | | | | |
| | | death occurred at M, from the couses and on the date stated above | | | | |
| | 22c. SIGNATURE M.D. ATTENDING STAFF PHYS. 22c. PHYSICIAN STAFF PHYS. 22d. ADDRESS NAME (Type) 4 14 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | | | | | |
| 1 | J.H. MESSLER, M.D. | OR CREMATORY , 23d-LOCATION (City, lowner county) (State) | | | | |
| | BURLANDEC 21-61 PIPECRE | EK CEM CARROLL COUNTY MO | | | | |
| 1 | ADDRESS UNION DRIDGE | 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| t. | | Uto 4 k | | | | |

THE RESIDENCE OF THE PROPERTY OF THE PARTY O AND LOND WAS DUST ASSESSED BY TO ASSESSED ASSESSED.

TC OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after own. Page 4 may be retained by the hospital or attending physician.

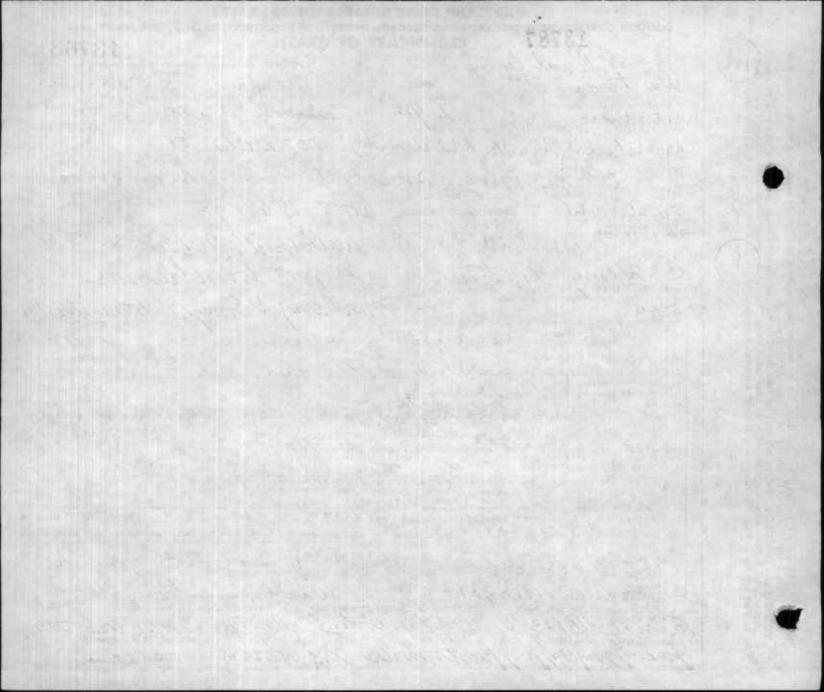
> TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and control in the page 3 should be detached for use as the burial-transit permit. Then page 5 should be detached for use as the burial-transit permit. Then page 5 should be detached for use as the burial-transit permit. Then page 5 should be detached for use as the burial, cremation, or removal, and in any event, within 72 hours after death. 6

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| 1- | 1 12 2 | 1000 | | | | |
|---------|--|--|--|--|--|--|
| 1. | PLACE OF DEATH Carroll County 2. USUAL RESIDENCE (Where decesed lived, If institution, Re | sidence before admission) | | | | |
| | Wes tong a tar Maryland 8. STATE Maryland 6. COUNTY M | shall | | | | |
| | b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and | give neerest town) | | | | |
| 11. | writer RURAL and give meerest town | ti | | | | |
| LVI | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | I O. IS RESIDENCE | | | | |
| N | | ON A FARM? | | | | |
| 1 | arrall County Hen. Hosp. Westmany 108 Willia It. | YES NO 4 | | | | |
| 3. | NAME OF DECEASED Month | Day Year | | | | |
| | (Type or print) Clure / Tulton Miller DEATH Dec. 2 | 11 1941 | | | | |
| 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH | EAR IF UNDER 24 HRS. | | | | |
| | Temple W WIDOWED & DIVORCED Oct 5. 1868 93 Months 0 | ays Hours Min. | | | | |
| 10a | . USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY MATHEMACE COUNTY & State, or Tables and Market 12 CTU | EN OF WHAT COUNTRY? | | | | |
| do | ne during most of working life, even if retired) | v 5 a | | | | |
| 13. | FATHER'S NAME | Control of the Contro | | | | |
| | C. 240 A At | | | | | |
| 15 | Triny Indion Hames witheren | | | | | |
| | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INTORMANT Addings. no. or unkown) (Ifyes give war or dates of service) | * | | | | |
| | no none Mrs Harrey H. meal White | unster My. | | | | |
| | 18. CAUSE OF DEATH (Enter only one couse per line for (e), (b), and (c).] | INTERVAL BETWEEN | | | | |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) EUROPAL Throngs | 12-19-41 | | | | |
| | 222.4 | 2 | | | | |
| | S32X DUE TO TEST | some | | | | |
| | Conditions, if eny, which geve rise to immediate cause | Trans | | | | |
| | (a), stating the underlying DUE TO | Some | | | | |
| | cause lest. (c) 5 | years | | | | |
| O | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT FELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN FART 1(6) 19. WAS AUTOPSY PERFORMED? | | | | | |
| AT | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. 20s. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Port II of item 18.) 0R CONTRIBUTING CAUSE OF DEATH CAUSE O | | | | | |
| TIFIC | 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury In Part I or Part II of item 18.) | | | | | |
| CER | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 7 | 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, † 20f. (City or town) (Coun | ly) (Stete) | | | | |
| MEDICAL | Hour e.m. While Not While fectory, street, office bldg., etc.) | | | | | |
| Z | p.m. 19 et work at work | 1 | | | | |
| | 21. I certify that (I) (this hospital) attended the deceased from 12-15 | | | | | |
| | saw the deceased alive on 12 21 19.61, and that death occurred at 1.5.M, from the causes and on the | e date stated above. | | | | |
| | 22e. SIGNATURE ATTENDING . MED. STAFF | 22b. DATE SIGNED | | | | |
| | | 2-21-41 | | | | |
| | 22c. PHYSICIAN'S | 4 | | | | |
| | NAME (Type) Lo. 13,1/ings/ea Westminster, | 2nd. | | | | |
| 22 | BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, fown or county) | (State) | | | | |
| | BENOVAL (Specify) 12/23/61 brest number (emile bostnums) | to and | | | | |
| 1 | The state of the s | CNATHOE | | | | |
| 24 | (Something the state of the st | | | | | |
| - | 2 Mylle of Wallmalle Matelle 26 61 arthur 8, 9 | Trave | | | | |
| TOP | | | | | | |



cian and constelly filled in by the funeral over carbon papers. Pages 1 and 2 should over within 72 hours after death ACAIN. Page 4 may be retained by the hospital or attending physician.

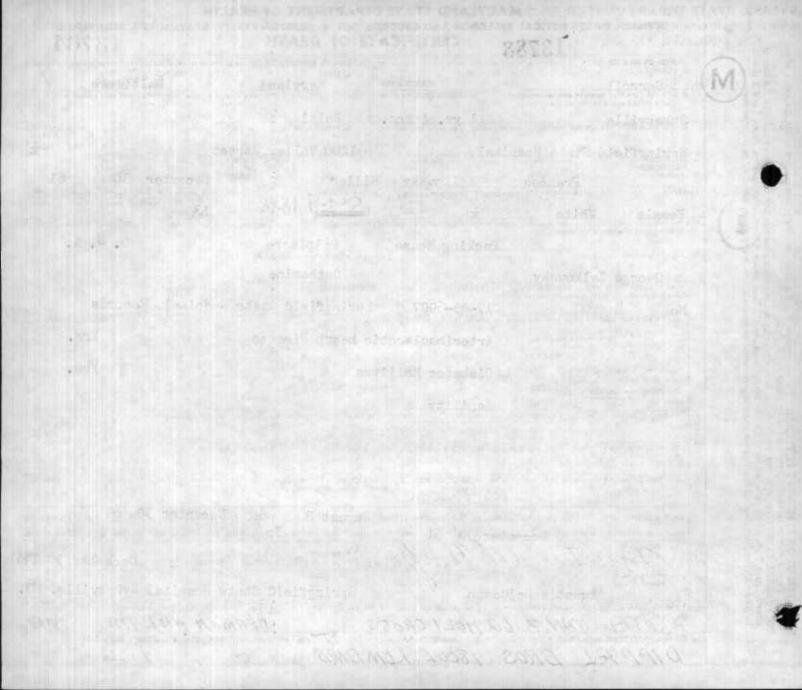
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and control tilled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

> VR A1S (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12700 CERTIFICATE OF DEATH
13764

| | 20100 | | | | |
|---------------|--|--|--|-----------------------------|--|
| 1. | PLACE OF DEATH a. COUNTY | | CE (Where daceased lived, If Institution | Residence before edmission) | |
| 0 | Carroll MARYLAND | e. STATE Marvla | b. COUNTY | imore / | |
| ľ | b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | | If outside corporata fimits, writa RURAL a | | |
| | write RURAL end give neerest town) | | 4 | | |
| | Sykesville 1 vr. 4 mos. | Baltimor | e 3 | V01-4 | |
| | d. WAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | | e. IS RESIDENCE | |
| | Control Street | | | ON A FARM? | |
| 3 | Springfield State Hospital Middle | 1200 Valle | | YES NO | |
| | DECEASED | Last | 4. DATE Month | Day Year | |
| | Type or print Frances Kalkowsky M | iller | December December | 30 1961 | |
| 5. | CEV 14 DOLOR | DATE OF BIRTH | 9. AGE (In years IF UNDER | | |
| | la l | Oct. 9 18 | last birthday) Months | Deys Hours Min. | |
| 10 | Female White WIDOWED DIVORCED | Unionoma' 'O' | 12 /2 AL | | |
| | B. USUAL OCCUPATION (Give kind of work one during most of working life, even if retired) | 11. BIRTHPLACE (Coun | ty & State, or foraign country) 12. C | CITIZEN OF WHAT COUNTRY? | |
| | | Baltimor | 20 | U. S. A. | |
| 13 | FATHER'S NAME Packing House | 14. MOTHER'S MAIDEN | | 0 | |
| | | | | | |
| | George Kalkowsky was deceased ever in u.s. Armed Forces? 16. Social Security No. 17. II | Catherin | е | | |
| 15 | WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. III | NFORMANT | Address | | |
| 11 | 227 02 6007 | Shringfield. | State Hospital Re | cords | |
| | 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] | phr Tugriera | Doade Hospital 110 | | |
| | PART I DEATH WAS CAUSED BY | | | ONSET AND DEATH | |
| | IMMEDIATE CAUSE (a) Arteriosclerotic heart Disease | | | | |
| | DUE TO | | | | |
| | | | | Yrs. | |
| | Conditions, if any, which gave rise to immediate cousa (b) Diabetes Mellitus | | | | |
| | (e), stating the underlying DUE TO | | | | |
| 10 | causa last. (c) Senility | | | C 3100 E 100 | |
| z | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT | RELATED TO THE TERMIN | NAI DISEASE CONDITION GIVEN IN PA | RT 1(a) 19. WAS AUTOPSY | |
| 5 | | I NELTHED TO THE TERMIN | THE BISENSE CONSTITUTION OF THE WAY | PERFORMED? | |
| A | | | | YES NO X | |
| CERTIFICATION | 208. ACCIDENT WAS UNDERLYING [206. DESCRIBE HOW INJURY OCCURED. | (Entar nature of injury in I | Pert I or Pert II of itam 18.) | | |
| CER | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| | | or or halling the | 1 000 100 | 10.11 | |
| MEDICAL | | CE OF INJURY (Home, farm ry, straat, office bldg., atc. | | ounty) (State) | |
| MET | p.m. 19 at work at work | | | | |
| | | Assemble O | 1060 . December 301 | 61 | |
| | 21. I certify that (I) (this hospital) attended the deceased from | | | | |
| | saw the deceased alive onDecember 3019.61, and that | death occured at | p.M, from the causes and on | the date stated above. | |
| | 22e. SIGNATURE | | | 22b. DATE | |
| | Clauren del Campo MI | DUIVE D | AED. STAFF PHYS. THE | ecember 30'196 | |
| | 27c. PHYSICIAN'S | 22d. ADDRESS | | | |
| | NAMÉ (Typa) | | a Ot-t- Hamital S | leografile MD | |
| | / Agustin DelCampo | Spriggiler | d State Hospital S | AKERATITE' IM. | |
| 23 | BURIAL, CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY O | R CREMATORY | 23d. LOCATION (City, town or cour | nty) (Steta) | |
| | REMOVAL (Specify) THN 2 12 HOLV CRASS | | GERMAN HILL I | PA MI | |
| | CHAINERAL DIRECTORIS CICALATURE | \$7 Tor | | CICNATURE | |
| 24 | FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | 'D BY REGISTRAR'S | SIGNATURE | |
| | DIPPKI BROS 1800 E, LON | BARD DATEN | 3 '62 winn 8, 1 | Trace | |
| _ | | | | | |

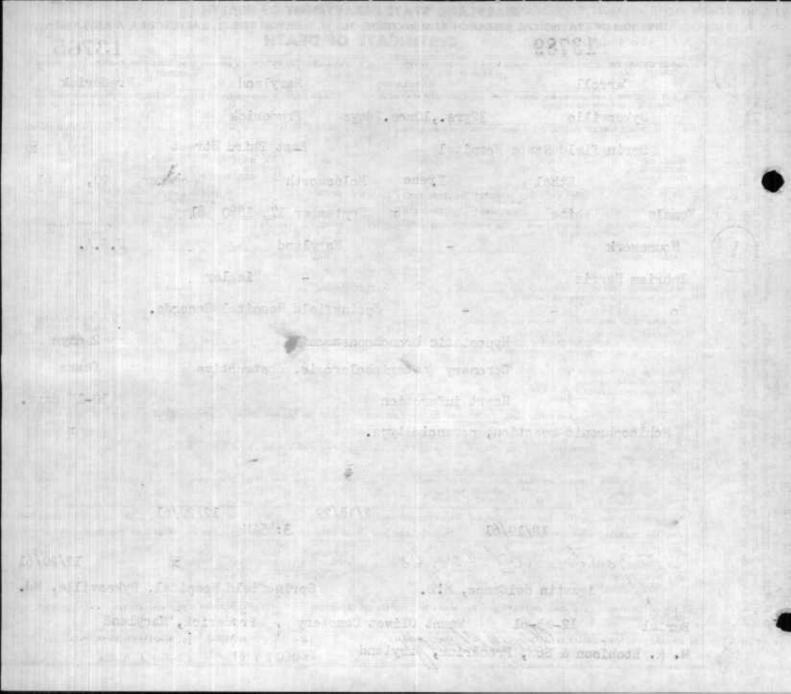


15

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, B

| DIVISION OF STATISTICAL RES | SEARCH AND RECORDS, | 301 W. PRESTON | STREET, BALTIMORE 1, | MARYLAND |
|-----------------------------|---------------------|----------------|----------------------|----------|
| 13789 | CERTIFICATE | OF DEATH | | 13765 |

| 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where decessed lived, If institution: Re | sidence before admission) | | | | |
|--|---|-------------------------------|--|--|--|--|
| Carroll Maryland | a. STATE Maryland b. COUNTY Fr | odomi ole | | | | |
| b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and | ederick | | | | |
| write RURAL end give nearest town) | | 4 1 1 | | | | |
| Sykesville 32yrs.,10mos.2 | | 011-2 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? | | | | |
| Springfield State Hospital | East Third Street | YES NO | | | | |
| 3. NAME OF First Middle DECEASED | Last 4. DATE Month | Day Year | | | | |
| (Type or print) Ethel Irene | Molesworth December | 20. 19 61 | | | | |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | DATE OF BIRTH 9. AGE (In years IF UNDER 1 Y | | | | | |
| Female White WIDOWED DIVORCED X | September 17, 1880 81 yrs. Months D | ays Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTE | | EN OF WHAT COUNTRY | | | | |
| cone during most of working life, even if refired) | | | | | | |
| Housework - | Maryland U | .S.A. | | | | |
| is. Patrick's NAME | 14. MOTHER'S MAIDEN NAME | | | | | |
| Enhriam Harris | 9 Ziegler | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unknown) (Ifyesgive wer or detes of service) | INFORMANT Address | | | | | |
| | national description of the seconds | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] | pringfield Hospital Records. | INTERVAL BETWEEN | | | | |
| PART I, DEATH WAS CAUSED BY: | | | | | | |
| IMMEDIATE CAUSE (*) Hypostatic bronchopneumonia 2 days | | | | | | |
| DUE TO | | | | | | |
| Conditions, if eny, which \ (b) Coronary arterio | sclerosis, obstructive | Years | | | | |
| gave rise to immediate cause | | | | | | |
| (e), steling the underlying cause last. Heart infarction | | 10-15 days. | | | | |
| | T DEL ATEN TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1 | | | | | |
| Schizophrenic reaction, paranoid type | | PERFORMED? | | | | |
| Schizophrenic reaction, paranoid type 20a. Accident was underlying 20b. Describe How Injury Occured Or Contributing Cause of Death (If Either, Notify Medical Examiner) | . (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| | or or natural to the left | | | | | |
| | CE OF INJURY (Home, farm, ory, street, office bidg., etc.) | y) (Slale) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/18/29, 19, to 12/20/61, 19, that (I) (we) last | | | | | | |
| saw the deceased alive on 12/19/61 19 and that death occurred a 15 AM from the causes and on the date stated above. | | | | | | |
| | death occurred av. T ANY - from the causes and on th | | | | | |
| aventus del Campo | ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. | 12/20/6 | | | | |
| 22 PHYSIGIAN'S | 22d. ADDRESS | | | | | |
| Agustin delCampo, M.D. | Springfield Hospital, Syk | esville, Md. | | | | |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY REMOVAL (Specify) 12-23-61 Count Olivet | | | | | | |
| Dun allen | | | | | | |
| M. R. Etchison & Manager Manager Manager M. R. Etchison & M. Etchison | 2Se. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SI | GNATURE | | | | |
| Me He Decition of Don't Lieuter Tour Astract | DADEC 27'61 Circhur & Tirs | MA | | | | |



FOR STATE HEALTH DEPT.

files. Health, o funeral director. Page ny delay is necessary, or your reflained the State please execute the certificate, writing the word "pending" in pendi in hem 18. Give Fages 1, 2, and 3 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may 1 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 may or its designated agent, prior to burial, cremation, or removal, and in any event within 72 here at

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1379 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13766

| 1. PLACE OF DEATH a. COUNTY | 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission |
|---|--|
| Carroll Maryland | * STAT Maryland b. COUNTY Carroll |
| b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |
| write RURAL end give nearest town) | V |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address) | Mt. Airy d. STREET ADDRESS la. IS RESIDENCE |
| | ON A FARM |
| 310 S. Main St. | 310 S. Main St. YES NO X |
| 3. NAME OF First Middle DECEASED | Last 4. DATE Month Day Yeer OF |
| (Typa or print) Thomas Oliver Mole | esworth Dec. 4 19 61 |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 | 3. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| Male White WIDOWED DIVORCED | May 22, 1887 The last birthday Months Deys Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTR | |
| done during most of working life, even if retired) | |
| Farmer Own farm | Kemptown, Md. USA |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
| John A. Molesworth | Ann Clay |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unknown) (Ifyesgivawarordetesofservice) | INFORMANT Address |
| | Ars Hilda M. Molesworth, Item 2 |
| 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | I INTERVAL BETWEEN |
| PART I. DEATH WAS CAUSED BY: | ONSET AND DEATH |
| IMMEDIATE CAUSE (e) | We chereon Mu |
| DUE TO | |
| Conditions, if any, which (b) | |
| geve rise to immediate cause (a), stating the underlying DUE TO | |
| cause lest. (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY |
| PH - The state of | PERFORMED? |
| 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (I | Enter neture of injury In Part I or Part II of item 18.) |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 208. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. | |
| U I I I I I I I I I I I I I I I I I I I | CE OF INJURY (Home, ferm, 20f. (City or town) (County) (Steta) |
| Hour a.m. While Not While p.m. 19 at work et work | |
| 21. I certify that I took charge of the remains described above, he | ald an Autopsy , Inspection , Inquiry , and in my opinion |
| death resulted from: Natural causes A. Accident . Suic | ide , Homicide , Undetermined manner |
| 0 5 | CHIEF MEDICAL EXAMINER |
| ACTUAL (Narah) | |
| SIGNATURE AUCUL | M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED |
| NAME (TYPE) JAMES T MARSH | DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) |
| 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF | |
| Burial Dec. 6,1961 Providence | Moth Kommtown Md |
| 23. FUNERAL DIRECTOR ADDRESS | 248. REC'D BY REGISTRAR 246, REGISTRAR'S SIGNATURE |
| Clin L'Molesunth Damascus, | Md |
| 3000 | DATE DEC 7 '61 C TANA & Harry |

CONGRADO CAL DESTANCES E CUPTURCACE OF DEATH STEM \$ Formania TO WE A POST brief Transport advice vera BULLET BULL MARKET PROMISE TO THE ROYALD IN CHILDREN THE REAL PROPERTY AND THE PER NOT and the state of t d no promote the contract of the land of the

| VISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY | YLANI |
|--|-------|
| 13791 CERTIFICATE OF DEATH 137 | 76" |

1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decassed lived, If institution, Residence before admission) e. COUNTY Maryland b. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) write RURAL and give nearest town) Sykesville 24vrs10mos12dvs Baltimore 14 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 3500 Ailsa Avenue YES NO T NAME OF Middle 4. DATE Month Year DECEASED 7,171ah Sellers 13 Muhl DEATH December 19 61 (Type or print) 6. COLOR OR RACE 7. MARRIED THE NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Female White December 6, 1905 WIDOWED [DIVORCED 56 yrs. 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired U.S.A. Telephone operator Maryland

14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Bertie Warfield James Edmond Feidler WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yas, no, or unkown) | (If yes give war or dates of service) Springfield Hospital Records 18. CAUSE OF DEATH (Enter only one causa per line for (a), (b), and (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchopneumonia Days IMMEDIATE CAUSE (e) DUE TO (b) Rheumatic heart disease Conditions, if any, which Years gava rise to Immediate cause DUE TO (a), stating the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? Schizophrenic reaction, paranoid type. NO 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.) 20a, ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,) 20f. (Cily or town) (County) (Stote) factory, street, office bldg., etc.) While Not While Hour a.m. et work D.m. 21. I certify that (I) (this hospital) attended the deceased from February 1, 19.37 to December 13 19.61, that (I) (we) last saw the deceased alive on. December 12.19.61..., and that death occured at 10AM rom the causes and on the date stated above. 22b. DATE 22e. SIGNATURE ATTENDING 61 SIGNED PHYS. DIRECTOR PHYS. 22c: PHYSICIAN'S 22d. ADDRESS NAME (Type) Springfield Hospital, Sykesville, Md. Agustin delCampo, M.D. CEMETERY OR CREMENTORY 23c. NAME OF (State) 23a. BURIAL, CREMATION, 23b. REMOVAL (Specify) 25b. REGISTRAR'S FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR

funeral within 24 hours the d 2 in by filled ir Pages and co physician remove please attending signed by the burial-transit has been the hospital or certificate as After this detached DIRECTOR: 0 VR A15 (4) 15M 9/60

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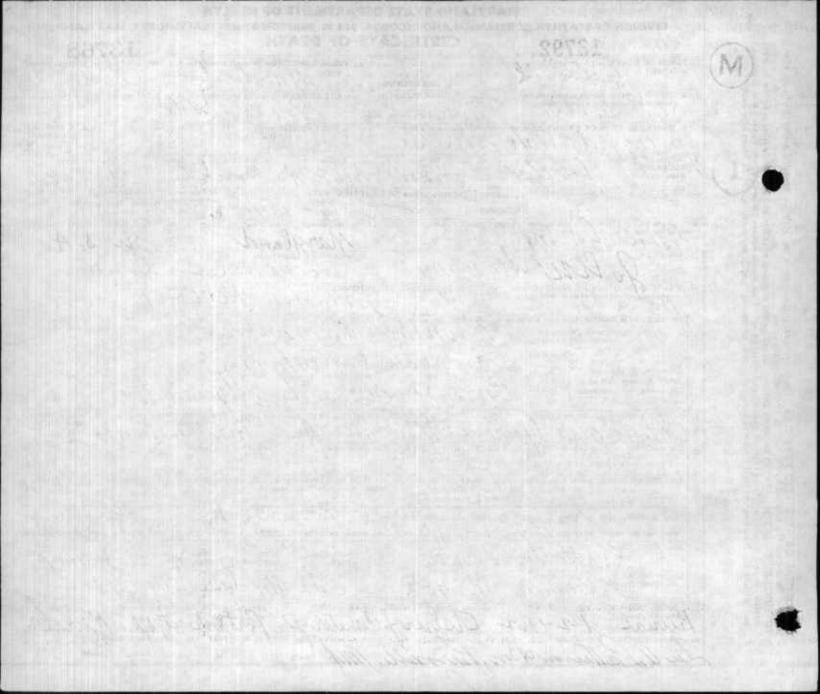
VR AtS (4)_ 1SM 7/61

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MADVI AND STATE DEDARTMENT OF HEALTH

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|------------------------------|--|-----------------------|
| DIVISION OF STATISTICAL RESE | ARCH AND RECORDS, 301 W. PRESTON STREET, | BALTIMORE I, MARYLANS |
| 13792 | CERTIFICATE OF DEATH | 12140 |

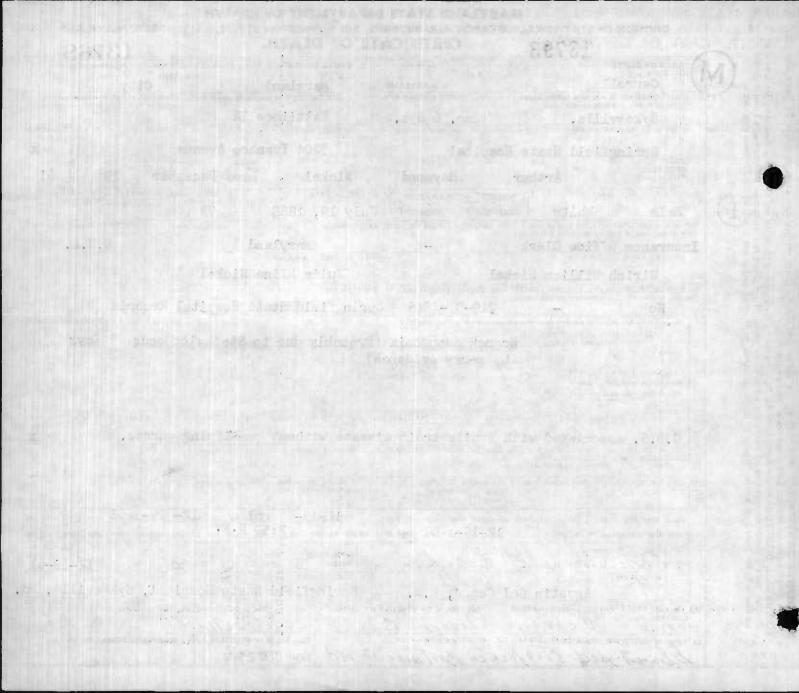
| ٧. | .0.0 | 10/00 |
|----|---|---|
| у. | 1. PLACE OF DEATH V | 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) |
| ľ | . COUNTY CATTOLL MARYLAND | a. STATE MANULAINS b. COUNTY (COLUMN) |
| | b. CITY OR TOWN (if outside corporate) limits, LENGTH OF STAY IN 16 | e. CITY OR TOWN (If guralde corporate limits, firsts RURAL and give nearest town) |
| | (write KUKKL and give peared town) | Dervi DILL |
| | SL NAME OF HOSPITAL OR INSTITUTION (If not in hospital cities threat address) | a lotter Olxin |
| | SL NAME OF HOSPITAL OR INSTITUTION (if not in hospital) give sheet address | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? |
| H | pringfield State Prospital | YES NO X |
| u | NAME OF Set Middle | Last 4. DATE Month Day Year |
| H | (Type or print) Tellal Maryle | MURPHY DEATH DUC. 3/ 196/ |
| D) | 5. SEX 6. COLOR OF RACE 7. MARRIED NEVER MARRIED 8. | DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| Н | WIDOWED DIVORCED [| 6-17-1896 (3) yrs. Months Days Hours Min. |
| H | 10a. USUAL OCCUPATION USINE kind of work 10b. KIND OF BUSINESS OR INDUSTR | 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? |
| | House Cultury | Maryland Dr. S. A. |
| Н | 15. FATHER'S NAVY D | 14. MOTHER'S MAIDEN NAME |
| ı | your unipry | Florence 6. Kyan |
| ı | 13. WAS DECEMBED EVER IN U.S. ARMID FORCES? 16. SOCIAL SECURITY NO. 17. II | NPORMAND Address |
| 1 | No | Hospital Records |
| | 18. CAUSE OF DEATH [Enter only one cause per light for (e), (b), and (c). | I INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: PYON Photo | neumonies ONSET AND DEATH |
| | IMMEDIATE CAUSE (e) | · ~ // |
| | DUE TO STONELLA | (Withmer |
| | Conditions, if any, which gave rise to immediate cause | 000/10/11 |
| | (a), stating the underlying DUE TO MYON (C) | caeseritie Museaudt |
| | cause last. (c) | often rouse Originality |
| | PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BETT NO. | RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY |
| | 204 ACCIDENT WAS UNDERLYING TO BEATH BUT NO. 204 ACCIDENT WAS UNDERLYING TO DESCRIBE HOW INJURY OCCURED. OF CONTRIBUTING TO CAUSE OF DEATH INF EITHER, NOTEY MEDICAL EXAMINES! | HARRESHOOLET ON THE SYCHEST NO 1 |
| , | 204. ACCIDENT WAS UNDERLYING OF 206. DESCRIBE HOW INJURY OCCURED. | (Enter nature of injury in Part I or Part II of item 18.) |
| | IF EITHER, NOTIFY MEDICAL EXAMINER | |
| | 3 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE | CE OF INJURY (Home, ferm, † 20f. (City or town) (County) (Steta) |
| | | pry, street, office bldg., etc.) |
| U | | 6-8- 11/2-31 |
| | 21. I certify that W (this hospital) attended the deceased from | |
| | | death occured at |
| | 223. SIGNATURE ON TENTE | ATTENDING MED. STAFF X 12-31-106 SIGNED, PHYS. DIRECTOR PHYS. |
| | 22c. PHYSICIAN'S | 22d. ADDRESS AL |
| | NAME (TYPEONSTAINTIN NEBER | Oak Sh; Sykerville, Us. |
| | | OR CREMATORY 23d_LOCATION (City, town or county) (State) |
| | REMOVAL ASpegay) W 7 17/19 | amotos it Patrolinit ul Pical |
| | 24 FUNERAL DIRECTOR STORIGNATURE ADDRESS | / ASS. REC'D BY REGISTRAX 25b. REGISTRAR'S SIGNATURE |
| | 24 FUNERAL DIRECTOR STOTOMATORE | 10. |
| 1 | - w Go Jallusm 4 son, furry rulle, | DATE JAN 3 '62 Cirlling & Through |
| | / ~ / | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1000

| PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence be a. STATE b. COUNTY Maryland c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | etore edmission) |
|--|--|
| Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. CITY OR TOWN (it outside corporate limits. C. IFNGTH OF STAY IN 1b. C. | |
| b. CITY OR TOWN (if outside comparate limits. LINGTH OF STAY IN 1b. | |
| write RURAL and give nearst lown) C. LENGTH OF STAT IN ID C. CITY OK TOWN (If outside corporate limits, write RURAL end give nearst lown) | |
| | est fown) |
| Sykesville, lmo. 6 dys. Baltimore 12 | - 7- |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. | . IS RESIDENCE ON A FARM? |
| Springfield State Hospital 5204 Ivanhoe Avenue | ES NO |
| 3. NAME OF First Middle Last 4. DATE Month Dey | Yeer |
| (Type or print) Arthur Raymond Nickel December 19 | 19 61 |
| 17. MUSICIAL TITLE TEN MUSICIAL | UNDER 24 HRS. |
| Male White WIDOWED DIVORCED July 19, 1888 73 yrs. Months Deys Ho | ours Min. |
| 108. USUAL OCCUPATION (Give kind of work 10h KIND OF BUGINESS OF INDUSTRY) 11 BIRTHIN ACE (County & Chile of County) 122 CITIZEN OF WIL | HAT COUNTRY |
| done during most of working life, even if refired) Insurance Office Clerk - Maryland U.S. | Δ |
| Insurance Office Clerk - Maryland U.S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME | • 62 • |
| Ulrich William Nickel Julia Kline Nickel | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address | |
| (Yes, no, or unkown) (Ifyes give wer or detes of service) | |
| No - 219-01-4845 Springfield State Hospital Records | |
| ONICEY | AND DEATH |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (6) Bronchopneumonia (Probably due to Staphylococcus Day | |
| | |
| by A ray overdoor | |
| Conditions, if any, which (b) | |
| (e), stating the underlying DUE TO | |
| cause lest. (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. W | PERFORMED? |
| 5 C.B.S. associated with senile brain disease without qualifying phrase. YES | NO T |
| E 20e. ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) | |
| ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH | |
| UIF EITHER, NOTIFY MEDICAL EXAMINER | |
| | (State) |
| 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) Hour a.m. While Not While factory, street, office bldg., etc.) | (Stete) |
| 20c. TIME OF INJURY Month, Dey, Year Hour a.m. While Not While et work street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year While Not While et work street, office bldg., etc.) | |
| 20c. TIME OF INJURY Month, Dey, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While et work 20d. INJURY OCCURRED factory, street, office bldg., etc.) 20f. (City or town) (County) | |
| 20c. TIME OF INJURY Month, Dey, Year Hour a.m. 20d. INJURY OCCURRED States of Injury (Home, ferm, factory, street, office bldg., etc.) (County) | (I) (we) las |
| 20c. TIME OF INJURY Month, Dey, Year Hour a.m. 19 20d. INJURY OCCURRED And While work 20m. 20m. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.) 21. I certify that (I) (this hospital) attended the deceased from 11-13, 19-61, to 12-19-19-61, that saw the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, from the causes and on the date says at the deceased alive on 12-19-19-61, and that death occurred at 2:50, and the deceased alive on 12-19-19-61, and the dec | (I) (we) las stated above |
| 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY MONTH, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY MONTH, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. TIME OF INJURY MONTH, Dey, Year 20d. INJURY OCCURRED thou factory, street, office bldg., etc.) 20c. | (I) (we) las |
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| 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED thour a.m. While work 19 twork 19 twork 19 the twork 19 twork 19 two deceased from 11-13-, 19 61, to 12-19-19 61, that saw the deceased alive on 12-19-19 61, and that death occured at 2:50, from the causes and on the date start of the causes are caused at the causes and on the causes are caused at the cause | (I) (we) las stated above 22b. DATE SIGNED 2-19-61 |
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| 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While Not While at work at work factory, street, office bldg., etc.) 21. I certify that (I) (this hospital) attended the deceased from 11-13, 19.61 to 12-19-, 19.61, that saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19-19.61, and that death occured at 2:50, from the causes and on the date saw the deceased alive on 12-19-19-19-19-19-19-19-19-19-19-19-19-19- | (I) (we) las stated above 22b. DATE SIGNED 2-19-61 ille, Me |



DIVISION OF STATISTICAL RESEARCH AND PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 13794 funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. COUNTY b. COUNTY the d 2 MARYLAND pue b. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town by d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) NAME OF Middle DECEASED (Type or print) DEATH 5. SEX 9. AGE (In years | IF UNDER 1 YEAR NEVER MARRIED Months WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? remove done during most of working life, even if retired) FARME 13. FATHER'S NAME ROLL plea 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unkown) | (Ifyesgive war or dates of service) signed by the hospital or attending physician. permit. 18. CAUSE OF DEATH (Enter only one cause par line for (a). PART f. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cremation, the burial-transit Conditions, if any, which certificate has been DUE TO (e), stating the underlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATI use prior 206. DESCRIBE RID V INJURY OCCURED, (Enter nature of Injury 20a. ACCIDENT WAS UNDER OR CONTRIBUTING [] CAUSE After this IF EITHER, NOTIFY MEDICAL EX detached 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bidg., etc.) While Not While Hour n.m. 3 should be det at work p.m. 21. I certify that (I) (this hospital) attended the deceased from C saw the deceased alive on. 22a. SIGNATE ATTENDING STAFF DIRECTOR PHYS PHYS. FUNERAL director, I 23a. BURIAL, CREMATION, 23b. REMOVAL (Specify) OI 24 FUNERAL DIRECTOR'S SIGNATURE 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 9/60 arthur S. Krous

RYLAND STATE DEPARTMENT OF HEALTH

e. IS RESIDENCE ON & FARM? YES NO

IF UNDER 24 HRS.

PERFORMED?

(County)

NO

(State)

22b. DATE

Hours

Day

1911 - 1827 - 1827 - 1828 - 18 MEZERATION OF WELL BEING GRANTING THE PROPERTY WILLY SEE STATES PAREST ON LEVISORS CONTRACTOR OF STREET BENDER OF STANDING OF STANDING price premineral -55/11/11/2/1/2/ Pleased of water of princes is of liver 10 de out 12 per 10 10 10 10 10 The service with the E, NE COCHINENS IS King Congress Strain Tolks Market 12 28 Charles States States In 18 Carlot after the state of the state of the

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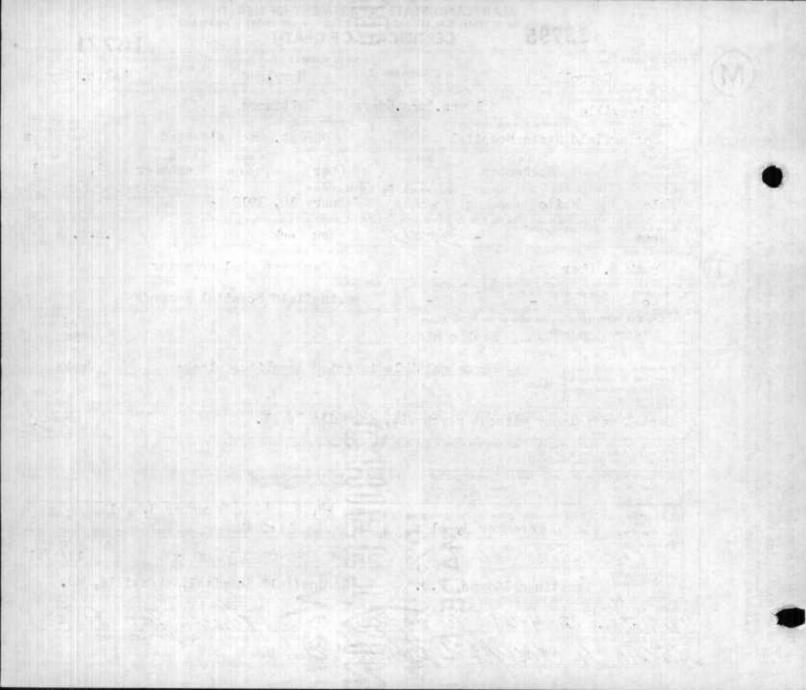
| | | | ARYLAND | | | | | |
|---|-----|----------|-------------------|----------|----------|----------|------------|------------|
| 4 | 0 0 | DIVISION | OF STATISTICAL CE | RESEARCH | AND RECO | ORDS - B | ALTIMORE 1 | , MARYLAND |
| L | 37 | 95 | CF | RTIFICA | ATE O | F DFA | TH | |

| | | 13195 | | CERTIFI | CATI | OF DEATH | | | 135 | 771 | |
|---------------|---|--|---------------------------|----------------------------|-----------|---|------------------------|------------------------------|-------------|-----------------------------|--------------------|
| | PLACE OF DEATH | | | N/ET J.P. | 2 | . USUAL RESIDENCE (Who | ere deceased | | Residence | befare admiss | ion) |
| C | | Carroll | | MARYL | AND | Mary | and | b. COUNTY | Ba: | lto.Cit | ty/ |
| Ł | CITY OR TOWN (IF RURAL ond give new Sykesvi | | ts, write | c. LENGTH OF STAY IT | | c. CITY OR TOWN (If or Baltin | | rate limits, write RUR | AL ond give | nearest tawr | 1) |
| (| OR INSTITUTION | AL (If not in hospital, g | | | | d. STREET ADDRESS 908 St. | Georg | e's Road | | _ | FARM? |
| | NAME OF DECEASED (Type or print) | Roch | este: | Middle | | Ober | 4. DATE OF DEATH | De cemb | er | / | Year 19 61 |
| 5. S | Male Male | 6. COLOR OR RACE White | 7. MARE | NEVER MARRIED DIVORCED | _ | January 14, | 1919 | | | YEAR IF UND | ER 24 HRS. Min. |
| 10a | . USUAL OCCUPATIO during mast af wark None | N (Give kind af wark of ing life, even if retired) | dane 10b. | - None | INDUSTR | New York | ar fareign co | ountry) | 1 | S.A. | OUNTRY |
| 13. | FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN N | | | | | |
| | Frank B. | . Ober | | | | Margaret | t Del | Rochester | | | |
| 15. (Yes | | R IN U. S. ARMED FOR If yes, give war or dates of s | | SOCIAL SECURITY NO. | 17, INFC | Springfield | Hospi | tal Recor | | | 11/31/ |
| | 18. CAUSE OF DEA | TH [Enter anly one co | use per li | ne far (o), (b), and (c).] | | | | | | INTERVAL BE | |
| | PART I. DEA | TH WAS CAUSED BY: JMMEDIATE CAUSE (a | S | epticemia | | | | | | Days | DEATH |
| | Conditions, if ar gove rise to in cause (o), stoting I lying cause lost. | DUE TO | T | arge multip | le in | afected decub | itus | ulcers | | Week | S |
| CATION | | iersignificant con eficiency v | DITIONS OF | ONTRIBUTING TO DEA | TH BUT NO | nbecile leve | NAL DISEAS | E CONDITION GIVEN | N IN PART 1 | (a) 19. WAS PERFO YES | AUTOPSY ORMED? |
| CERTIFICATION | | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES | CRIBE HOW INJURY OC | CURRED. | (Enter nature of injury in F | ort I ar Por | t II af item 1B.) | | | |
| MEDICAL | 20c. TIME OF INJURY Hour a.m. p. m. | Y Month, Day, Yes | 20d. I While of wor | Nat while | | E OF INJURY (Home, form ry, street, office bldg., etc. | | ar town) | (Ca | unty) | (State |
| | 21. I certify tha | t (I) (this haspital |) attende | r 36 61, and | ram Ji | une 28, 19 ath accurred at 11: | | December 3 the causes and | | , , | , |
| | 22a. SIGNATURE | retin | de | el Coms | 20 M. | ATTENDING MI | ED. | STAFF PHYS. | | 12/ | 25. DATE 35/61 |

22d. ADDRESS Springfield Hospital, Sykesville, Md. Agustin delCampo, M.D. BURIAL CREMATION: 236 DATE THEREOF 23d. LOCATION (City, town, or sounty) FUNERAL DIRECTOR'S SIGNATURE 256 REGISTRAR'S SIGNATURE \$50. REC'D BY REGISTRAR DEC 6 Ciriling S. Hima '61 DATE

VR A15 (4) 15M 9/59

22c. PHYSICIAN'S NAME (Type)

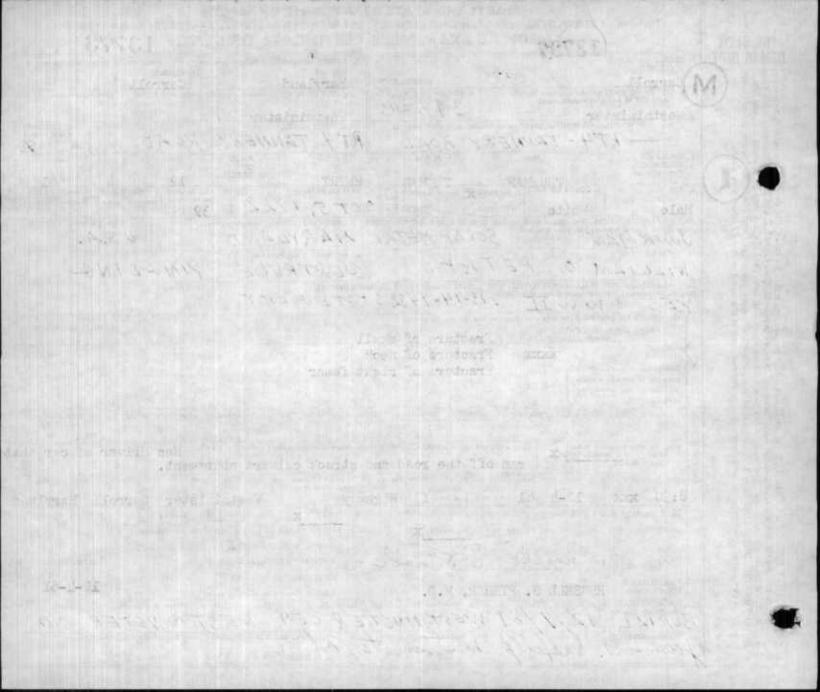


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 9 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) e. COUNTY Page b. COUNTY a. STATE Carroll MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give negrest town) write RURAL and give negrest town vrs./19 days Baltimore #11 Svkesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 3828 Tudor Arms YES NO K Springfield State Hospital 3. NAME OF ODRAG 4. DATE Middle Month DECEASED OF GDEM (Type or print) DEATH 19 61 Walter George.Jr. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 5, SEX 9. AGE (In yeers | IF UNDER 1 YEAR IF UNDER 24 HRS. last birthdey) white male WIDOWED DIVORCED 7-6-1879 yrs. 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if relired) U.S.A. Theatrical stage hand Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Walter Odell, Sr. Charlotte Doubleday 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) ! (If yes give wer or detes of service) Springfield State Hospital Records 214-03-5496 18. CAUSE OF DEATH [Enter only one ceuse per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Heart failure due to rheumatic heart disease IMMEDIATE CAUSE (e) and mitral valve insufficiency. vear 9 Conditions, if eny, which geve rise to immediate cause "pending" DUE TO as (e), sleting the underlying 5 ceuse lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(*) 19. WAS AUTOPSY QUALITYING PART 1. CBS with cerebral arteriosclerosis without execute the certificate, writing the word Hematoma left scalp. YES X NO pluods 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury In Pert I or Pert II of item 18.) PRIMARY Or CONTRIBUTING CAUSE OF DEATH. forwarded to the Chief L DIRECTOR: Page 3 MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) 20c. TIME OF INJURY Month, Dey, Yeer (County) (Stete) factory, street, office bldg., etc.) Not While et work et work 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection Inquiry and in my opinion Natural causes X , Accident , Suicide Homicide Undetermined manner death resulted from: CHIEF MEDICAL EXAMINER designated ASSISTANT MEDICAL EXAMINER DATE SIGNED should be for FUNERAL 1 DIGNATURE DEPUTY MEDICAL EXAMINER 12/2/61 EXAMINER:6 James T. Marsh, M.D. NAME (Type) Address (Street, city, town, or county) 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) S REMOVAL (Specify) Kingsville, Maryland St. Johns Church Burial Ö 24O 246. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR ADDRESS O Mitchell & Sons, Inc. 1900 Eutaw arthur & House 5M 7/59 DATE

MARYLAND STATE DEPARTMENT OF HEALTH

START SO WASHING PROCESSES LABOURAGES WEST ST TOTAL THE SAME OF The state of the s

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) COUNTY b. COUNTY CITY OR TOWN (if outside corporate limits, MARYLAND Maryland Carroll c. LENGTH OF STAY IN 16 c. CITY OR TOWN (II outside corporate limits, write RURAL and give neerast town) write RURAL and give nearest town) 6 Westminister Westminister d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give streat address) a. 15 RESIDENCE ON A FARM? TANNERY YES NO SO NAME OF DECEMBED OF (Type or print) DEATH 1961 THOMAS 7. MARRIED NEVER MARRIED 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) WIDOWED T White 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) WILLIAM YINGLING 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Fracture of skull IMMEDIATE CAUSE (a) Fracture of neck ROEXOC Conditions, il eny, which Fracture of right femur gave rise to Immediate cause (a), stating the undarlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19, WAS AUTOPSY PERFORMED? NO 4 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of Injury in Pert I or Pert II of item 18.) 20e. EXTERNAL CAUSE WAS Was driver of car that PRIMARY | or CONTRIBUTING ran off the road and struck culvert abuttment. 20d. INJURY OCCURRED A. 20e. PLACE OF INJURY (Home, farm, : 20f. (City or town) (County) (State) factory, street, office bldg., atc.) 12-4 1061 at work at work Highway Westminister 21. I certify that I took charge of the remains described above, held an Autopsy 😿 . Inspection . Inquiry death resulted from: Natural causes Accident X Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S 12-4-61 RUSSELL S. FISHER, M.D. NAME (Type) Address (Street, city, town, or county) 22a. BURIAL, CREMATION, 22b. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stale)



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ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death: Page 4 in by the funeral director, and 2 should be filed with TO FUMERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely it page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| 3798 | CERTIFICATE | OF DEATH |
|----------------|-------------|----------|
| 0 5 /0 _ H / X | | |

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| Rea. Dist | No | O. | - | - | - 3 |

| 20.00 | | | | | | | | |
|--|-------------------------------|---|--------------------------|------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH Carr Off | MARYLAND | 2. USUAL RESIDENCE (WI | b | If institution: Resident COUNTY | | | | |
| b. CITY OR TOWN (If autside corporate limits, write c. LENGTH OF | STAY IN 16 | c. CITY OR TOWN (If | | | | | | |
| RURAL and give nearest town) Svkesville | 13/2/21 | X R. D. | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | e e Tita | sourg | e. IS RESIDENCE ON A FARM? | | | |
| Pullem Nursing Home | | | | | YES NO I | | | |
| 3. NAME OF DECEASED (Type or print) ESTELL9 | Aiddle | Dowler S | 4. DATE OF DEATH | Manth | Doy Year 196/ | | | |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER M | AARRIED T | B. DATE OF BIRTH | 9. AGE | (In years IF UNDER | TYEAR IF UNDER 24 HRS. | | | |
| Female White WIDOWED DIVE | ORCED | Dec. 23, 18 | | yrs. Months | Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind af work dane during mast af working life, even if retired) | ESS OR INDUS | TRY 11. BIRTHPLACE (State | ar foreign country) | 12. CIT | IZEN OF WHAT COUNTRY? | | | |
| Housework | | Marvlar | nd | | U. S. A. | | | |
| 13. FATHER'S NAME | S. 15-3 | 14. MOTHER'S MAIDEN I | NAME | • | | | | |
| ? Powers | | 2 | 2 | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURIT | Y NO. 17. II | NFORMANT | • | Address | | | | |
| (Yes, no, or unknown) (If yes, give war or dates of service) | Pu | llen Nursin | ng Home. | Sylvesyi | lle. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and | | · · · · · | is momes | DYACDVI | INTERVAL BETWEEN | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | nor | ug (fel | en real | 2) | ONSET AND DEATH | | | |
| 331 × DUE TO 7., | | | | | 0 | | | |
| Conditions, if any, which) the family legice. | | | | | | | | |
| gave rise to immediate DUE TO | 100 | 1 2 | | | | | | |
| lying cause last. (c) Celebra | coose (o), stating the under- | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO Large Cle Cur 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OR CONTR | O DEATH BUT | NOT RELATED TO THE TERMI | A S CONDI | TION GIVEN IN PAR | 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 1 | | | |
| 206. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJU OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | JRY OCCURRED |). (Enter nature of injury in | Part I ar Part II af ite | m 18.) | | | | |
| 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED While Not while at wark at wark at wark | fac | ACE OF INJURY fHome, farm stary, street, affice bldg., etc | n, 20f. (City ar tawn |) (0 | County) (State) | | | |
| 21. I certify that I attended the deceased from | 10. | Z- , 196 [, to | 12. 18 | 19 6 / that 1 | ast saw the deceased | | | |
| | | | O M from the o | anna and an th | ne date stated abave. | | | |
| direction, and | mai deam | accorded dit | ADDRESS (Street, city | or town state) | DATE SIGNED | | | |
| SIGNATURE Same Okn for | nan | | resuil | le H. | Le 17.18-61 | | | |
| PHYSICIAN'S Sani Oku | tin | an | | | 1 | | | |
| 22o. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF | | | 22d. LOCATION (Cit | y, tawn, ar caunty) | (State) | | | |
| Burial 12-20-1961 Morgar | n Chap | el Cemeter | Carro | 11 Co. | Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | 24a. REC' | D BY REGISTRAR | 246. REGISTRAR'S SIG | | | | |
| C. M. Waltz, Winfield, Ma | arvlan | d DATEC | 2 2 '61 | arthur S. H | intel [®] | | | |
| | | | | | | | | |

READ OF STATISTICS AND SAFES Company of the STS-15 CO. STS-15

letely filled in by the funera carbon papers. Pages I and 2 nt, within 72 hours after death LOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be call. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and director, page 3 should be detached for use as the burial-transit permit. Then please remove carbe be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with

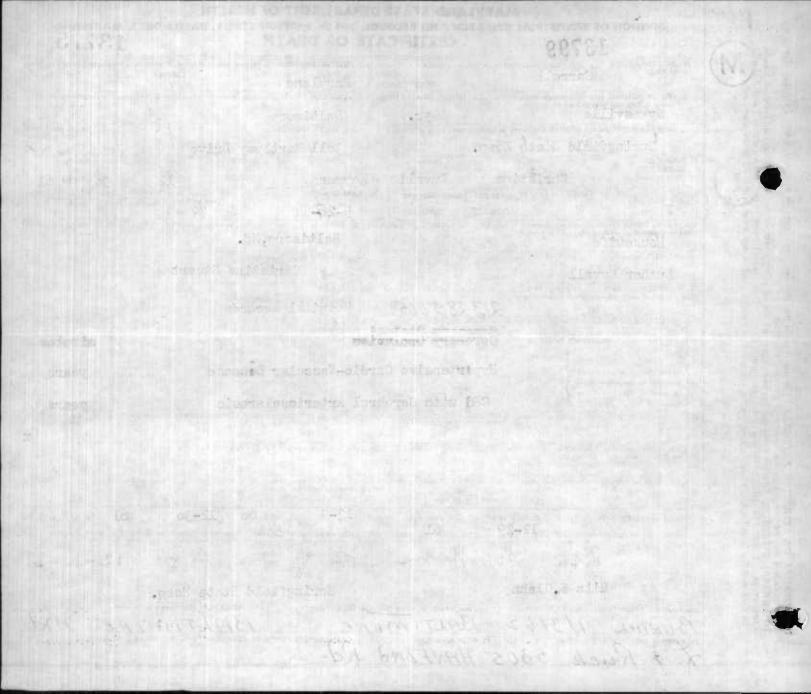
> VR A15 (4) 15M 7/61

executed within 24 hours after

MARYLAND STATE DEPARTMENT OF HEALTH

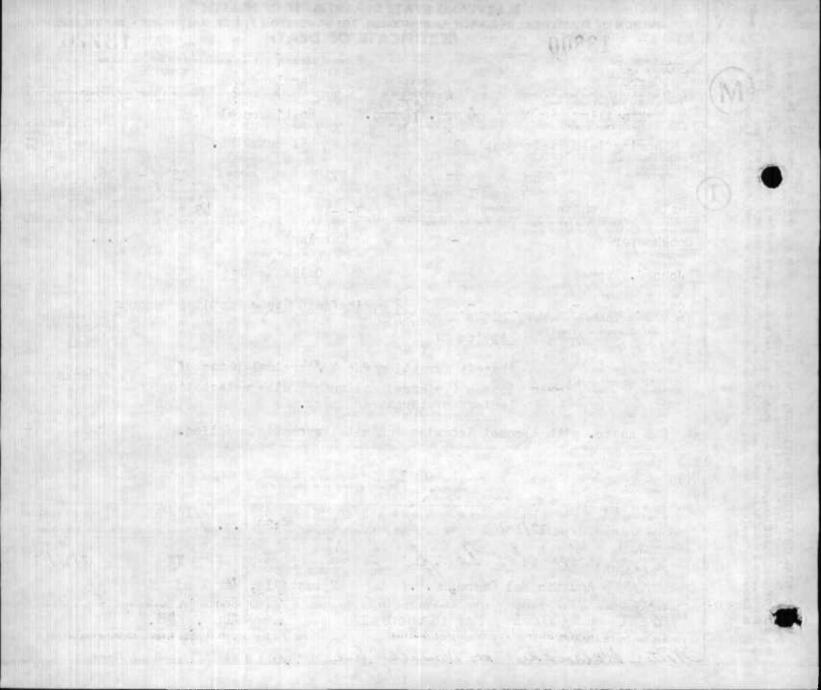
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1370 CERTIFICATE OF DEATH 13775 13799

| 1. PLACE OF DEATH | | | 200 | 1 2. USUAL RESIDEN | ICE (Where dec | eased lived. If | Institution: Resid | enca befora | ad mission |
|---|---|--------------------|-----------------------------|---|--|------------------------------|--------------------|----------------|------------|
| e. COUNTY | Carroll | | MARYLAND | Maryland | | b. COUN | | 20,000 | |
| write RURAL end | f outside corporate limi give nearast town) | ts, | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN | (If outside corpo | rate limits, write | a RURAL and giv | re neerast tov | vn) |
| Sykesvi | lle | | l yr. | Baltimor | _ | | 3V | 01-4 | |
| | | | pital, giva street eddress) | d. STREET ADDRESS | | | | | A FARM? |
| | field Stat | | 0. | 3oll Nor | thway D | rive | | | NO [X |
| 3. NAME OF DECEASED | First | | Middla | Last | 4. DATE OF | Month | n Da | Yaq | ır |
| (Type or print) | Chris | | Duvall | Raymond | DEATH | 1: | 2 | 30 19 | 61 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIE | NEVER MARRIED 8 | . DATE OF BIRTH | 9. | AGE (In years last birthday) | IF UNDER 1 YEA | _] | R 24 HRS. |
| F | W | WIDOWE | DIVORCED | 5-25-84 | | 77 yrs. | Months Days | Hours | Min. |
| 10a. USUAL OCCUPAT dona during most of wo Housewi | rking lifa, evan if ratire | 10b. Ki | ND OF BUSINESS OR INDUSTR | Baltimor | The state of the s | oreign country) | 12. CITIZEN | OF WHAT | COUNTRY |
| 13. FATHER'S NAME | | - | | 14. MOTHER'S MAIDEN | NAME | | | | |
| Luther I | uvall | | | 2 Chr | istina | Stuart | | | |
| 15. WAS DECEASED EV | ER IN U.S. ARMED FOR | CES? 16. | SOCIAL SECURITY NO. 17. | INFORMANT | | Address | | | |
| (Yas, no, or unkown) (I | ryas give wer or detes of s | ervica) 11 | 3185115 | Hospital H | Records | | | | |
| 18. CAUSE OF D | EATH [Enter only ona | cause par li | ne for (a), (b), end (c).] | 1105 DI Gar I | recor as | | 1.1 | NTERVAL BE | TWEEN |
| PART I. DEAT | H WAS CAUSED BY: | | | l am | | | | ONSET AND | |
| 140 | IMMEDIATE CAUSE (.) | | ronary Occlusi | LOII | | | | minu | tes |
| | DUE TO | TTes | | 3. 17 3 | | | | | |
| Conditions, if eny | | ну | pertensive Car | rdio-Vasculai | r Deseas | e | | year | cs |
| (e), steting tha u | DITT TO | | | | N | | | | |
| causa last. |) (c) | | BS with Cerebi | cal Arterios | clerosis | | | vear | rs |
| PART II. OTHER | SIGNIFICANT CONDI | TIONS CON | TRIBUTING TO DEATH BUT NO | OT RELATED TO THE TERMI | INAL DISEASE C | ONDITION GIV | 'EN IN PART 1(a) | | ORMED? |
| | AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES | CRIBE HOW INJURY OCCURED | . (Entar netura of injury in | Part I or Part II | of item 18.) | MARIN | | |
| ZOC. TIME OF INJU | | er 20d. I Whila | Not Whila fact | CE OF INJURY (Homa, fari tory, street, office bldg., etc | | or town) | (County) | | (Stata) |
| Petrill | 19 | | | 12_0 | 10 60 | 70 2- | 167 | | |
| | hat (I) (this hospi | tal) attend | ded the deceased from. | 14-7 | 19QQ 10 | ΩC | , 190_L., | , that (I) | (we) las |
| saw the deceas | ed alive on | | 19.61 , and that | death occured at | 2AM, from | the causes | and on the | date state | d above |
| 220. SIGNATURE | Riter | 8. | fleelin , | | MED. DIRECTOR | STAFF PHYS. | 17 | -30 | SIGNED |
| 22c. PHYSICIAN'S NAME (Type) | Rita S.Gla | hn | U | 22d. ADDRESS Springf: | ield Sta | the Hos | n. | | |
| 23a. BURIAL, CREMATI | ON, 236. DATE THE | REOF | 23c. NAME OF CEMETERY | | | TION (City, to | | (5 | itata) |
| BURIAL (Spacify) | 1/3/6 | 2 | BALTIMO | Re | BA | LTIN | MORE |) | nd |
| DIRECTOR | 's signature | 305 | HARFORD | Rd- DATE DATE | C'D BY REGISTE | RAR 25b. REG | GISTRAR'S SIGN | LATURE | |
| 1 / 12 | -0.70 | | | JAI | 4 02 | Chr. | west S. Tha | UA | |



| | | MARYLAND ST | TATE DEPAI | RTMENT OF | HEALTH | |
|------------|---------------|--------------|--------------|------------|---------------------|------------|
| DIVISION O | F STATISTICAL | RESEARCH AND | RECORDS, 301 | W. PRESTON | STREET, BALTIMORE 1 | , MARYLAND |
| 1 | 3800 | CERT | IFICATE O | F DEATH | | 13776 |

| 1. | PLACE OF DEATH | | 0.00 | | 1 | 2. USUAL R | ESIDEN | CE (Where da | scaesed livad, If | | Residenc | e befora e | dmission) |
|---------------|---|--------------------------------------|--------------|----------------------------|------------|-------------------------------------|----------|-----------------|--------------------------------|------------|-------------|------------|---------------------------------|
| | county Carrol] | | | | | a. STATE | arvl | and | b. COU | 4TY | | V | |
| - | b. CITY OR TOWN (if | outside corporate limi | its, | c. LENGTH OF STAN | Y IN 1b | | | | orata limits, writ | a RURAL an | nd giva n | aarasi low | n) |
| | | giva nearast town) | | 6 23 day | | · T | 2-7-4 | | 1 | 2 | 111 | 1-4 | |
| | d. NAME OF HOSPITA | | if not in ho | ospital, giva streat addre | mons | d. STREET | | more # | 1 | | V 6 | | SIDENCE |
| | 1 | field State | e Hos | pital | | 8 | 351 E | utaw S | t. | | | | NO X |
| 3. | NAME OF DECEASED | First | | Middla | | Last | | 4. DATE | Mont | h | Day | Yaar | |
| K | (Type or print) | John | | Patrick | | RYAN | | DEATH | 7.4 | - | 16, | , ,, | |
| 1) | SEX | 6. COLOR OR RACE | 7. MARRI | ED X NEVER MARRIED | B | DATE OF BIRTH | 1 | 9 | . AGE (In years last birthday) | | | IF UNDER | |
| Y | male | white | WIDOW | ED DIVORCED | | 3-4-12 | | | 19 yrs. | Months | Days | Hours | Min. |
| 10 | a. USUAL OCCUPATION | ON (Giva kind of worl | 10ь. | KIND OF BUSINESS OR | INDUSTR | Y 11. BIRTHPLA | CE (Coun | ity & State, or | foreign country) | 12. CI | TIZEN OF | WHAT | OUNTRY? |
| | Bookkeeper | king lifa, aven if refire | ad) | - | | Marv | land | | | U. | S.A. | | |
| | . FATHER'S NAME | | 1 | | | 14. MOTHER'S | | NAME | | | | - | |
| | Talan T Da | | | | | 0 | elia | | | | | | |
| 15 | John J. H | | CES? 16 | SOCIAL SECURITY NO |) [17] T | | erra | 2.7 | Addres | | | | |
| | es, no, or unkown) (If: | | | | | | | | | | 1 - | | |
| | no | | | | | ringfie! | ld St | ate Ho | spital | Kecor | | | |
| | The second second | | causa par | line for (a), (b), and (c) | -} | | | A-11 | | | | RVAL BET | |
| | | WAS CAUSED BY: MMEDIATE CAUSE (a) | Sep | ticemia | | | | | | | | Jarri - | |
| | 14-1 | DUE TO | | | | | | | | | 1 | Jays 7 | |
| | Conditions, if any, | which) (b) | Abs | cess format | ion | due to t | termi | nal ph | ase of | | | | |
| | gava risa to immedia | te causa | | | | | | | | | 7 | Teeks | |
| | (a), stating the un | derlying | | gue (primar | | - | _ | .un met | astatic | | | | |
| - | | SIGNIFICANT CONDI | | ions of thr | | | | NAI DISEASE | CONDITION GIV | /FN IN PAR | T 1(a) 19 | . WAS A | LITOPSY |
| ATIO | | | | 1 Intoxicat | - | | | | | | | PERFO | RMED? |
| CERTIFICATION | 20a. ACCIDENT WA OR CONTRIBUTING [(IF EITHER, NOTIFY | S UNDERLYING CAUSE OF DEATH | | SCRIBE HOW INJURY O | | | | | | | | | |
| | | | 1 | | | es of billing o | | 1 001 101 | | 16 | | | 151-1-1 |
| MEDICAL | Hour a.m. | Y Month, Day, Ye | Whi at wo | laNot Whila | | CE OF INJURY () ory, straat, offica | | | y or lown) | (Co | uniy) | | (Stata) |
| | | at (I) (this hospi | tal) atte | nded the deceased | from | 1/19/55 | | 19 to | 12/16/ | 61 19 | tl | nat (1) (| we) last |
| | and the deserted | d alive on 12 | 17616 | 119, ar | nd that | death occur | 5: | 20 pam | the causes | and on | the de | to state | d above |
| | 22a. SIGNATURE | di alive oii | 1.000 | 1 0 | id illai | dealli occur | ur | | 1 1110 000303 | and on | 1110 00 | | DATE |
| | 228. SIGNATURE | atra c | 101 | Combi | | ATTENDIN | | MED. | STAFF PHYS. XX | | | 10/26 | SIGNED |
| | 22c PHYSICIAN'S | VERBLA C | 100 | a rigge | , M | 22d. ADD | | JIKECTOK L | J FILLS. ALA | | | 12/10 | 0/61 |
| | NAME (Type) | Agustin | del C | ampo M.D. | | | | lle, Ma | ryland | | | | - go, ery yo, go, ery de de Grâ |
| 23 | BURIAL, CREMATIC | 1 | | 23c. NAME OF CE | | | | _ | ATION (City, to | - | ty) | (5. | lele) |
| | Burial | 12/20/ | 91 | New Cath | ear.s | 1 | | Fal | | d. | | | |
| 24 | FUNERAL DIRECTOR | SSIGNATURE | | ADDRESS | | 0 | 25e. REC | C'D BY REGIS | TRAR 256. RE | GISTRAR'S | SIGNAT | URE | |
| 1 | Walter A | alrowsk | i . | 1005 Dunsal | 260 | Kil. | DATE | C 1 9 '61 | | muy & | Thank | | |
| - | 7.93 | | | | | | | | | | | | |



| MARYLAND | STATE | DEPARTM | ENT OF | HEALTH |
|--------------------|----------|-------------|----------|---------------|
| ION OF STATISTICAL | RESEARCH | AND RECORDS | - BALTIM | ORE 1, MARYLA |

13801 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If autside corporate limits, write c, LENGTH OF STAY IN 16 TOWN (If autside corporate limits, write RURAL and give nearest lown) BURAL and give nearest town) Westminster d_NAME OF HOSPITAL (If not in hospi give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO NAME OF Middle 4. DATE Month Year Day DECEASED (Type or print) DEATH 196 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years last birthdoy) 5. SEX B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS Months Doys Hours Min. DIVORCED | WIDOWED [10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. #IRTHPIACE (State or foreign country) doring most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME LeondA 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO Address none TOWN 1B. CAUSE OF DEATH [Enter only one cause pen line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **DUE TO** Conditions, if ony, gave rise to immediate **DUE TO** cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 160 19. WAS AUTOPSY PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Hame, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) Hour o. m factory, street, office bldg., etc.) While Not while at wark at wark p. m

21. I certify that (1) (this hospital) attended the deceased from... 196/ 1.to LLNe , and that death accurred a 1990, from the causes and an the date stated above. saw the deceased alive and 22N/ SIGNATURE 22b DATE

PHYS DIRECTOR PHYS PHYSICIAN'S 22d, ADDRESS NAME (Type)

23o. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, tayin, or county) (State) REMOVAL (Specify) VIA

24. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 25h. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR Orthun & Kross

HINDER OF STADISHES OF GEATH Leckain A. Lustes ... Schaller ... Schaller TONE METERS DIAMAS TONAS

filled in by the funeral within 24 hours after TO SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expected. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician and consideration, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, the filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within

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| M | ARYLAND | | | | LENT OF | |
|---------------------------|------------|---------|---------|-------|---------|-----------|
| DIVISION OF STATISTICAL R | ESEARCH AN | ID RECO | RDS, 30 | 01 W. | PRESTON | STREET, B |
| 12000 | CER | RTIFICA | ATE (| OF I | DEATH | |

12000

| | 400116 | | | | | | | | |
|------------------------------|--|------------------|-------------------------|---------------------------|---------------|------------------|---------------------------------|---|-------------------------------|
| 1. PLACE OF DEAT | Н | | | | SIDENCE | (Where dec | | | ence before admission) |
| Carr | oll | | MARYLAN | a. STATE | Marvl | and | b. COUN | NTY | V |
| b. CITY OR TOWN | (if outside corporate limi | 15, | c. LENGTHLOF STAY IN | | | | ate limits, writ- | RURAL and giv | e neerest town) |
| | d give nearest town) | | 1/ days | | | | | 2.181 | 1.1 |
| | SVILLE | 6 1 - 1 1 | 15yrs./6mos | | | more # | 17 | .5 VO | o of preintables |
| | | | | d. STREET A | DOKESS | | | | a. IS RESIDENCE ON A FARM? |
| Spri | ngfield Stat | te Hosp | ital | | 1715 | N. Pav | son St. | | YES NO |
| 3. NAME OF DECEASED | First | | Middle | Last | | DATE OF | Mont | | y Yaar |
| (Type or print) | Ida | | Reba | SCHEIN | | DEATH | 12 | - 2 | , 1961 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH | | | AGE (In years last birthday) | | |
| female | white | WIDOWED | DIVORCED | March 1 | 895 | | 66 yrs. | Months Deys | Hours Min. |
| 10a. USUAL OCCUPA | TION (Giva kind of work | 10b. KIN | O OF BUSINESS OR INDU | | | | | 12. CITIZEN | OF WHAT COUNTRY |
| done during most of w | orking life, evan if retire | d) | | T.1.1 | | | | | 11150 |
| Hospital 1 | летрег | | | Lithu | | 1145 | | U me | ws7 |
| 13. TATTIER STAME | | | | 14. MOTHER'S | MAIDEN NA | 1ME | | | |
| Maurice I | | | | | g Vin | nick | | | |
| 15. WAS DECEASED E | VER IN U.S. ARMED FOR (Ifyesgive war ordatas of se | CES? 16. SC | OCIAL SECURITY NO. 1 | 7. INFORMANT | | | Address | | |
| no | (11)039170 #010100103013 | 1 4160) | - | Springfie | 18 Ste | ate Ho | enitel | Sylvagy | SIL MIG |
| | DEATH [Enter only one | cause par lina | for (a), (b), and (c).] | DOLTHERTE | I'M O'VE | 200_110 | DIATORT 9 | | NTERVAL BETWEEN |
| | TH WAS CAUSED BY: | | | | | 1.1 2 | | 0 | DNSET AND DEATH |
| 4 | IMMEDIATE CAUSE (a) | Bilat | eral pulmon | ary artery | embo. | Lism d | ue to | | |
| 4 1 8 | DUE TO | | | | | | | | |
| Conditions, if an | 1-1. | proba | bly embolis | m dus to i | nfecte | ed dec | ubitus | ulcers. | days |
| gave rise to immed | DITE TO | | | | | | | | |
| (a), stating the cause last. | directiving | Heart | failure du | e to rheim | etic 1 | heart | digage | | days/years |
| | (c) (c) | | | | | | | | |
| 2 | in diditility in contra | 10110 001111 | | NOT RECOVED TO TH | | E DIDENCE CO | | 111111111111111111111111111111111111111 | PERFORMED? |
| Manic Manic | Depressive | | | | | | | | YES NO |
| | YAS UNDERLYING A | 2Db. DESCR | IBE HOW INJURY OCCU | RED. (Enter nature of i | injury in Par | t I or Part II o | of itam 18.) | | |
| U (IF EITHER, NOTIF | MEDICAL EXAMINER | | | | | | | | |
| 20c. TIME OF INJ | URY Month, Day, Ya | or 20d. IN | JURY OCCURRED 20e. | PLACE OF INJURY (H | | 20f. (City o | or town) | (County) | (State) |
| Hour a.m. | | While at work | Not While | factory, street, office b | ildg., etc.) | | | | |
| | 19 | | | F 2 F 1/ | | | 10 0 /3 | | |
| 21. I certify | that (I) (this hospit | al) attende | d the deceased fro | m 2-12-40 | , 19 | , to | 14-4-01 | ,, 19, | that (I) (we) last |
| saw the decea | sed alive on12- | 2-61 | 19, and t | hat death occure | d at.4.4 | M, from | fhe causes | and on the | date stated above |
| 22a. SIGNATURE | -1 | 0.0 | 0 1 | | | | | | 22b. DATE |
| 2/10 | wern | dell | Campo | M.D. PHYS. | | ECTOR | STAFF PHYS. | | 12-2-61 |
| 22c PHYSICIAN'S | 5 | , | | 22d. ADDR | ESS | | | | 1~ ~ 01 |
| NAME (Type | Agustin d | lel Cam | po, M.D. | Syke | sville | e, Mar | yland | | |
| 23. AURIAL, CREMA | TION, 236. DATE THER | | 23c MAME OF CEMETE | RY OB PREMATORY | | 23d. LOCA | TION (City, to | wn or county) | Tar (State) |
| Durial | 1/2-4-6 | 1 1 | marre | 1 felow | | | rallo | | ma |
| 24 JUNERAL DIRECTO | R'S SIGNATURE | y | (ADDRESS) | 1 | 25a. REC'D | 8Y REGISTR | AR 256. RE | GISTRAR'S SIGN | ATURE |
| Jack Lei | ous see 2 | 100 € | sutaw 12 | ace | DATE | | - | elin & Ken | |
| | Control of the Contro | | | 1 | DEC | F-161 | ' (| TUNI | |

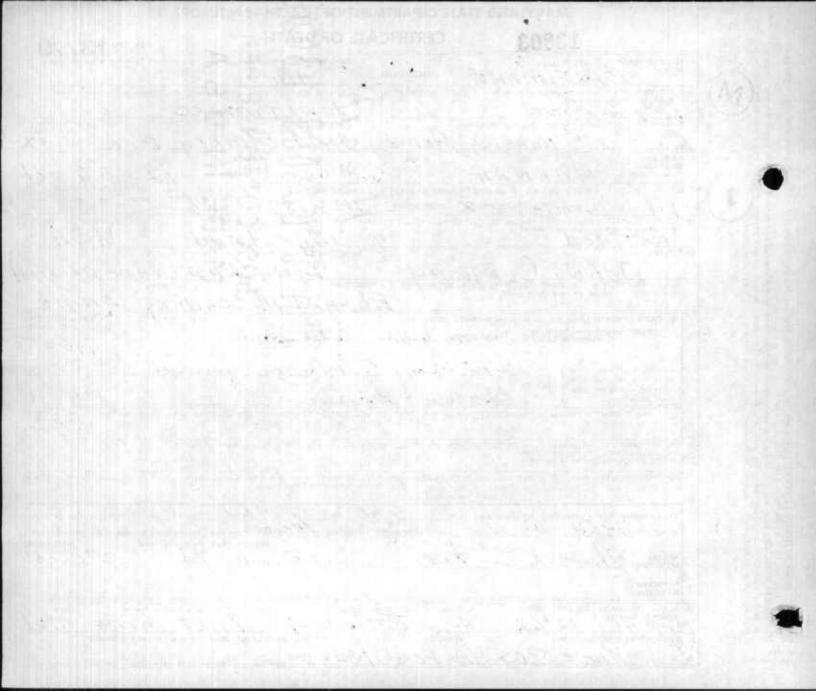
BALTIMORE 1, MARYLAND

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£20000000 W GDC . TOOT THE THE PARTY Also all the late of the end of the charge AND THE REAL PROPERTY AND ADDRESS OF THE PARTY OF THE PAR A stay world A A TANK LABOR TO THE TANK OF THE PARTY OF T Marine to the There of the test of the tes Jack Lever He Two Cutter three

| ARYLAND | STATE DEPARTMENT | OF HEALTH—BALTIMORE, 18 | |
|---------|------------------|-------------------------|--|
| | | | |

| | 13803 CERTIFIC | AIE OF DEATH | Reg. Dist. No. 1919 |
|---------------|---|---|---|
| 1. | PLACE OF DEATH CARROLL COUNTY BIAIKITISMERE MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution of STATE b. COUN | |
| | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. CITY OR TOWN (If outside corporate limits, write | e RURAL ond give nearest town) |
| | NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION | d. STREET ADDRESS | ON A FARM? YES NO X |
| 3. | NAME OF First Middle DECEASED (Type or print) | Lost 4. DATE OF DEATH | Anoth Day Year 2 9 19 Col |
| 5. | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In year lost birthdo) | ors IF UNDER 1 YEAR IF UNDER 24 HRS. Y) Months Doys Hours Min. |
| 10 | USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 1 10 10 10 | 12. CITIZEN OF WHAT COUNTRY? |
| 13. | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | 434 |
| | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (If yes, give wor or dates of service) | INFORMANT AND CALLY | NAME UNKNOWN |
| - | 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] | OurARd III, SC41111 | INTERVAL BETWEEN ONSET AND DEATH |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which (b) Cleart lives, | arterisestoris Cenerale | 1960 70 |
| | gove rise to immediate couse (a), stating the under-lying couse lost. DUE TO Slink dues 70 A | Unguer - | 29 Dec 61 |
| CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> B | UT NOT RELATED TO THE TERMINAL DISEASE CONDITION | GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO |
| | 20a. ACCIDENT WAS UNDERLYING ☐ CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | RED. (Enter noture of injury in Port I or Port II of item 18.) | |
| MEDICAL | 20c. TIME OF INJURY Month, Doy, Year Hour o. m. While Not while of work of work | PLACE OF INJURY (Home, form, 20f. (City or town) foctory, street, office bldg., etc.) | (County) (State) |
| | 21. I certify that I ottended the deceosed from 9 | th occurred at 0130th, from the couses | |
| | ACTUAL SIGNATURE There and E. Falle | M.D. Stehenelle Min | vn, stote) DATE SIGNED 29LCec61 |
| | PHYSICIAN'S NAME (Type) | | |
| 1 | BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY REMOVAL (Specify) 1/2/62 New CH | OR CREMATORY 22d. LOCATION (City, low 37 hedral 1317LT) | more Md. |
| 23. | FUNERALDIRECTOPYSSIGNATURE ADDRESS - L. Ruck 5305 HARFORD | Red DATE 2 162 | EGISTRAR'S SIGNATURE |



10 E VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CEDTIFICATE OF DEATH

| | 13804 | CERTIFICA | IE OF DEATH | | 13780 |
|--|--|--|---|---|--|
| 1. PLACE OF DEATH o. COUNTY | Carroll | MARYLAND | 2. USUAL RESIDENCE (WHO o. STATE Maj | ryland b. COUNTY | Residence before admission) Frederick |
| b. CITY OR TOWN (III MIDD AND AND AND AND AND AND AND AND AND A | foutside corporate limits, write arest tawn) | c. LENGTH OF STAYIN 16 | c. CITY OR TOWN (IF of Thurs | outside corporote limits, write RUR. moht rural | AL and give nearest town) |
| d. NAME OF HOSPITA OR INSTITUTION Brookite | AL (If not in hospital, give street Ld Manor Nurs | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) | John | Arthur S | Seiss Lost | 4. DATE Month OF DEATH DOC . | 20 Day Year |
| s. sex male | 6. COLOR OR RACE 7. MARI | | B. DATE OF BIRTH Jan. 31, 1 | | FUNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. |
| during most of wark | N (Give kind of work done 10b. ing life, even if retired) | KIND OF BUSINESS OR INDU | STRY 11. BIRTHPLACE (State Maryl: | | U.S.A. |
| 3. FATHER'S NAME | ge Seiss | | 14. MOTHER'S MAIDEN N | ry McGrath | |
| | of of a constant of constant | social security No. 17. III | Cloyd W. | Address Seiss Emmit | sburg, Md. |
| Conditions, if or gove rise to it couse (a), stating lying couse lost. | DUE TO ny, which (b) | eneralized | artivó sa | lerotte | Gears |
| ICATIC | | | | | I IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO |
| | S UNDERLYING 20b. DES CAUSE OF DEATH MEDICAL EXAMINER) | CRIBE HOW INJURY OCCURRE | D. (Enter noture of injury in | Part I or Port II of item 18.) | |
| ZOc. TIME OF INJURY Hour o. m. p. m. | While | 60 | ACE OF INJURY (Home, farm ctory, street, office bldg., etc | | (County) (State |
| saw the deceas | t (I) (this haspital) attended alive an 12/19/6 | | | | , 19, that (I) (we) las an the date stated above |
| 220. SHANGURE | H. Carical | 4 | M.D. ATTENDING M. DI | ED. STAFF PHYS. | 1 2/20/6/ |
| NAME (Pype) | | cofe | Union | , BRILE, | MARYLAND. |
| BUT 18 (Specify) | 12-23-61 | | Cemetery | | Md. Fred. Co. |
| Tarmer Director | S SIGNATURE EUR | ADDRESS | 36.3 | 0.0 - 104 | RAR'S SIGNATURE |
| 21. I certify that saw the decease 22a. S. THA UPE 22a. S. THA | t (I) (this haspital) attended alive an 12/19/6 | ded the deceased fram ded the deceased fram deceased fram. | death accurred at 19. M.D. ATTENDING M. PHYS. DI 22d. ADDRESS 22d. ADDRESS R CREMATORY Comotory 25a. REC. | ED. STAFF RECTOR PHYS. D BRILE 23d. LOCATION (City, town, or Thurmont, or Thurmont, or Registrar 25b. REGISTR | an the date stated about 22b. DAT 12/10/6/ MAIZY AND COUNTY) Grote CRAR'S SIGNATURE |

. nin and a sales of impall and . . . DESCRIPTION OF THE PARTY OF THE The second of the second secon

| | 1380 | 5 | CERTIFIC | ATE OF DE | | .IIMORE, I | | 01010 |
|---|---|---------------------|-----------------------------------|---|-----------------------------------|--|----------------------------------|---|
| 1. PLACE OF DEATH a. COUNTY | Co. | | MARYLAND | 2. USUAL RESIDEN | ICE (Where decease | ed lived. If institution b. COUNTY | Reg. Dist. Non: Residence before | |
| b. CITY OR TOWN (If RURAL ond give near Westmin | rest town) | s, write c. LENG | GTH OF STAY IN 16 | c. CITY OR TOV | 11 1 | prate limits, write RU | | earest town) |
| d. NAME OF HOSPITAL OR INSTITUTION | | ive street address) | Hospital | d. STREET ADD | RESS | / | | e. IS RESIDENCE ON A FARM? YES NO |
| 3. NAME OF DECEASED (Type or print) | Pavid | t | Middle A | Shaffer | 4. DATE OF DEATH | Decemb | | ay Year |
| s. sex Male | 6. COLOR OR RACE | 7. MARRIED X | DIVORCED | B. DATE OF BIRTH | 1911 | 9. AGE (In years last birthday) 50 yrs. | Months Days | R IF UNDER 24 HR Haurs Min. |
| Oa. USUAL OCCUPATION during mast of warking | g life, even if retired) | lone 10b. KIND OI | F BUSINESS OR INQ | Vir | ginia | country) | 12. CITIZEN O | A . |
| 3. FATHER'S NAME | ie Sh | after | | Curr | il Inl | wlan | | |
| (Yes, no, or unknown) | yes, give war or dates of se | 713-0. | 5-32097 | MYS Davis | a-tha | Her, hr. | thins | ti md B |
| PART I. DEATH Canditions, if ony gove rise to im cause (o), stating th lying cause lost. | WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO , which mediate e under- | . (0- | roule | ry Th | lesas | is | | ERVAL BETWEEN SET AND DEATH |
| |) (c) | DITIONS CONTRIB | JTING TO DEATH BU | T NOT RELATED TO TH | E TERMINAL DISEAS | E CONDITION GIVE | N IN PART 1(a) | 19. WAS AUTOPS PERFORMED? YES NO |
| | UNDERLYING []] CAUSE OF DEATH EDICAL EXAMINER) | 206. DESCRIBE HO | OW INJURY OCCURR | ED. (Enter noture of in | jury in Part I or Pa | rt II of item 18.) | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Manth, Doy, Yea | While No | CCURRED 20e. P t while work | LACE OF INJURY (Honoctory, street, office bloom | ne, form, 20f. (Cit dg., etc.) | y or town) | (County) |) (State |
| 21. I certify the alive an | t I attended the | deceased from | | 7, 1961., 1 h accurred at/2 M.D. Wels | | | an the date | w the decease stated abov DATE SIGNE |
| 20. BURIAL, CREMATION REMOVALY (Specify) | 1/3/6 | 2 0 | AME OF CEMETERY | OR CREMATORY | 22d. LOCA | TION (City, town, or | thun | (State) |
| 23. FUNERAL DIRECTOR'S | SIGNATURE A | estmin | odress | ed. 24 | a. REGIS NEEDS | TRAR 246. REGIS | TRAR'S SIGNATU | |

ONE LAND Of Ble LONGE RESERVED TO A SECOND PORTION OF THE PERSON OF THE PE Maria Library (1984) - Name of Carlos States of the state THE TANK OF THE PARTY OF THE PA TO STATE OF THE PARTY OF THE PARTY. PROBLEM BELLEVILLE BY BY BUTTON TO

TO FORTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after with. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. VR A1S (4) 1SM 7/61

| I. PLACE O | F DEATH | | | 2. USUAL RESIDE | NCE (Where de | eesed lived, If I | nstitution: Resid | lence bafore edmis |
|--|--|--|--|--|--|--|--|---|
| a. COUNT | Carroll | | MARYLAN | e. STATE Mar | yland | b. COUN | | lto.City |
| b. CITY OF | R TOWN (if outside corp | orata limits. | c. LENGTH OF STAY IN | | | rate limits, write | The state of the s | - U |
| write F | RURAL end give neerest esville | town) | 1 mo.19 days | | more 14 | | 3 | V01-4 |
| | | TUTION (if not in h | nospital, give street address) | d. STREET ADDRES | | | | l e. IS RESIDE |
| | | | | | | Dank | | ON A FA |
| . NAME O | ingfield St | first | Middla Middla | 4000 | Harford | Month | D | YES NO |
| DECEAS: | ED | Edward | 7 | Soellers | OF DEATH | | - | - |
| . SEX | | | P, | | | Decemb | | |
| | | | RIED NEVER MARRIED | 8. DATE OF BIRTH | 9. | AGE (In years last birthday) | Months Days | |
| Male | Whit | | WED TO DIVORCED | \$-25-1874 | | 87 yrs. | | |
| Oa. USUAL | OCCUPATION (Giva kin most of working life, eve | nd of work 10b. | KIND OF BUSINESS OR IND | JSTRY 11. BIRTHPLACE (Con | unty & State, or f | oreign country) | 12. CITIZEN | OF WHAT COUN |
| Bak | | | - | Marylan | nd | | Ţ | J.S.A. |
| 3. FATHER'S | NAME | | | 14. MOTHER'S MAIDE | N NAME | | | |
| Aug | ust Soeller | S | | Carolin | ne - unk | nown | | |
| 5. WAS DEC | EASED EVER IN U.S. AR | MED FORCES? 1 | 6. SOCIAL SECURITY NO. | | 00.20.20 | Address | | |
| res, no, or u | nkown) (Ifyesgivewero | ordetes of service) | 218-10-1114 | Springfiel | d Hospi | tal Reco | rde | |
| 18. CAT | JSE OF DEATH [Enter | only one cause pe | | opinigine. | La Moobi | oar week | | INTERVAL BETWEE |
| | | | | | | | | |
| PAI | RT I. DEATH WAS CAUS | SED BY: M | | arction | | | | ONSET AND DEAT |
| PAI | RT I. DEATH WAS CAUS | AUSE (e) | yocardial inf | erction | | | | |
| 4 | - 10 - 1 | DUE TO | yocardial inf | | lan dia | 0.000 | | Days |
| Condition | IMMEDIATE C | DUE TO | yocardial inf | erction ic cardiovascu | ılar dis | ease | | ONSET AND DEAT |
| Condition geva risa | - 10 - 1 | DUE TO | yocardial inf | | ılar dis | ease | | Days |
| Condition geva risa (a), stati ceuse les | is, if any, which to immediate cause ing the underlying t. | DUE TO (b) A) DUE TO (c) | yocardial information | ic cardiovascu | | | | Days Years |
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| Condition geva risa (a), staticeuse les PART C.B | is, if any, which to immediate cause ing the underlying t. III. OTHER SIGNIFICAN Sassoc. WI | DUE TO (b) DUE TO (c) IT CONDITIONS CO th cerel NG 20b. D | yocardial information of the supportant supp | ic cardiovascu T NOT RELATED TO THE TERM Clerosis with | ainal disease cout qual: | ondition give | | Years 19. WAS AUTO PERFORME |
| Condition geva risa (a), stati ceuse les PARI C.B | IMMEDIATE CO. Ins. if any, which to immediate cause the underlying the Underlying to the Underlying the Underlyin | DUE TO (b) DUE TO (c) IT CONDITIONS CO THE CONDITIONS CO TO CO | yocardial information of the substitution of t | ic cardiovascu TNOT RELATED TO THE TERM Clerosis without URED. (Entar nature of Injury I | n Part I or Part II | ONDITION GIVE I fying of item 18.) | | Years 19. WAS AUTO PERFORME |
| Condition geva risa (a), staticeuse les PARI C.B. | IMMEDIATE CO. Its, if any, which to immediate cause and the underlying to the underlying the | DUE TO (b) DUE TO (c) IT CONDITIONS CC th ceret NG | potributing to DEATH BUDGET ATTENTION OF THE STREET OF THE | ic cardiovascu T NOT RELATED TO THE TERM Clerosis witho | n Part I or Part II | ONDITION GIVE I fying of item 18.) | N IN PART 1(a) | Years 19. WAS AUTO PERFORME YES NO |
| Condition geva risa (a), staticeuse les PARI C.B. 20a. ACC OR CONTI (IF EITHER 20c. TIME Ho | IMMEDIATE CO. Its, if any, which to immediate cause ing the underlying to the under | DUE TO (b) DUE TO (c) IT CONDITIONS CC th ceret NG | pocardial information of the property of the p | IC CARDIOVASCU T NOT RELATED TO THE TERM CLEROSIS WITHOUT URED. (Entar nature of Injury PLACE OF INJURY (Home, for factory, street, office bldg., e | AINAL DISEASE COUT QUAL | ONDITION GIVE ITYING of item 18.) | (County) | Years 19. WAS AUTO PERFORME YES NO |
| Condition geva risa (a), staticeuse les PARI C.B. PARI C.B. C.B. COR CONT (IF EITHER 20a. ACC OR CONT (IF EITHER 21. I. C.C.) | ins, if any, which to immediate cause ing the underlying t. III. OTHER SIGNIFICAN S. ASSOC. WI Dhrase. IDENT WAS UNDERLY! RIBUTING CAUSE OF, NOTIFY MEDICAL EX. E OF INJURY Month ur a.m. p.m. artify that (I) (thi | DUE TO (b) DUE TO (c) IT CONDITIONS CC Th ceret NG — 20b. D F DEATH AMINER) 19 20b. at ceret Wh 19 s hospital) after | ontributing to DEATH BU Dral arteriosciescribe HOW INJURY OCCURRED 20a. INJURY OCCURRED 20a. Indice Not While at work at work anded the deceased from | T NOT RELATED TO THE TERM CLE OF INJURY (Home, fe factory, street, office bldg., e | orm, 20f. (Gity | or town) | (County) | Years 19. WAS AUTO PERFORME YES NO (Stete |
| Condition geva risa (a), stati ceuse les PARI C.B. 20a. ACC OR CONT (IF EITHER 20c. TIM Ho saw the saw the | IMMEDIATE CO. Its, if any, which to immediate cause the underlying the Underlyin | DUE TO (b) DUE TO (c) IT CONDITIONS CC Th ceret NG — 20b. D F DEATH AMINER) 19 20b. at ceret Wh 19 s hospital) after | ontributing to DEATH BU Dral arteriosciescribe HOW INJURY OCCURRED 20a. INJURY OCCURRED 20a. Indice Not While at work at work anded the deceased from | IC CARDIOVASCU T NOT RELATED TO THE TERM CLEROSIS WITHOUT URED. (Entar nature of Injury PLACE OF INJURY (Home, for factory, street, office bldg., e | orm, 20f. (Gity | or town) | (County) | Years 19. WAS AUTO PERFORMED NO (Stellar (I) (we) date stated ab |
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| Condition geve rise (a), staticeuse les PARI C.B. 20e. ACC OR CONT (IF EITHER 20e. TIM Ho | IMMEDIATE CO. Ins, if any, which to immediate cause ing the underlying to the under | DUE TO (b) DUE TO (c) IT CONDITIONS CC Th ceret NG — 20b. D F DEATH AMINER) 19 20b. at ceret Wh 19 s hospital) after | ontributing to DEATH BU Dral arteriosciescribe HOW INJURY OCCURRED 20a. INJURY OCCURRED 20a. Indice Not While at work at work anded the deceased from | IC CARDIOVASCU T NOT RELATED TO THE TERM Clerosis without URED. (Entar nature of Injury I PLACE OF INJURY (Home, for factory, street, office bldg., e omn ovember 2., ,, that death occured at: ATTENDING PHYS. | orm, 20f. (Gity 1961, td) | or town) | (County) | Years 19. WAS AUTO PERFORMED NO (Stellar (I) (we) date stated ab |
| Condition geva risa (a), statiliceuse les PARI C. B. 20a. ACC OR CONT (IF EITHER 20c. TIM Ho | IMMEDIATE CO. Its, if any, which to immediate cause the underlying the Underlyin | DUE TO (b) DUE TO (c) IT CONDITIONS CO th ceret (NG 20b. D F DEATH AMINER) (b) 19 20b. D Wh 19 s hospital) atte | ontributing to DEATH BUDY arteriosclerot: ONTRIBUTING TO DEATH BUDY arteriosclerot: DESCRIBE HOW INJURY OCCURRED 20a. A. INJ | IC CARDIOVASCU T NOT RELATED TO THE TERM Clerosis without PLACE OF INJURY (Home, for factory, street, office bldg., e | n Part I or Part II nrm, 20f. (City itc.) 20f. td. | or town) complete the causes at STAFF PHYS. | (County) | Years 19. WAS AUTO PERFORME YES NO (Stell 1 that (I) (we) date stated ab 22b. DA 12/21/ |
| Condition geva risa (a), staticeuse les PARI C.B. 20e. ACC OR CONT (IF EITHER 20e. TIM Ho 21. I ce saw the 23. SURIAL, 23a. BURIAL, 23a | IMMEDIATE CO. Ins. if any, which to immediate cause ing the underlying it. II. OTHER SIGNIFICAN S. ASSOC. WI. Dhrase. CIDENT WAS UNDERLY! RIBUTING CAUSE O. NOTIFY MEDICAL EX. FOF INJURY Month or a.m. p.m. artify that (I) (this deceased alive or any artify that (I) (This deceased alive or any artify that II) | DUE TO (b) DUE TO (c) IT CONDITIONS CO th ceret (NG 20b. D F DEATH AMINER) (b) 19 20b. D Wh 19 s hospital) atte | ontributing to DEATH BUDY arteriosclerot: ONTRIBUTING TO DEATH BUDY arteriosclerot: DESCRIBE HOW INJURY OCCURRED 20a. A. INJ | IC CARDIOVASCU T NOT RELATED TO THE TERM Clerosis without URED. (Entar nature of Injury PLACE OF INJURY (Home, for factory, street, office bldg., e) omnovember2, , , , , , , , , , , , , , , , , , | n Part I or Part II orm, 20f. (City te.) 1961, td. 20AM from MED. DIRECTOR | or town) complete the causes at STAFF PHYS. | (County) 21,1962 and on the | Years 19. WAS AUTO PERFORME YES NO (Stell 1 that (I) (we) date stated ab 22b. DA 12/21/ |
| Condition geva risa (a), staticeuse less (b) (a) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c | IMMEDIATE CO. Ins. if any, which to immediate cause ing the underlying it. II. OTHER SIGNIFICAN S. ASSOC. WI. Dhrase. CIDENT WAS UNDERLY! RIBUTING CAUSE O. NOTIFY MEDICAL EX. FOF INJURY Month or a.m. p.m. artify that (I) (this deceased alive or any artify that (I) (This deceased alive or any artify that II) | DUE TO (b) DUE TO (c) IT CONDITIONS CO th ceret (NG 20b. D F DEATH AMINER) (b) 19 20b. D Wh 19 s hospital) atte | ontributing to DEATH BUDGER arteriosclerot. ONTRIBUTING TO DEATH BUDGER ARTERIOSCO. DESCRIBE HOW INJURY OCCURRED 20a. A. INJURY OCCURRED 20a. | T NOT RELATED TO THE TERM Clerosis with Colerosis w | n Part I or Part II orm, 20f. (City te.) 1961, td. 20AM from MED. DIRECTOR | or town) complete the causes a staff Phys. & contal, Spital, | (County) 21,1962 and on the | Years 19. WAS AUTO PERFORME YES NO (Stete 1 that (1) (we) date stated ab 22b. DA SI 12/21/ Lle, Md. |
| Condition geva risa (a), stati ceuse les PARI COR CONT (IF EITHER 20c. TIM Ho | IMMEDIATE CO. Ins. if any, which to immediate cause ing the underlying it. II. OTHER SIGNIFICAN S. ASSOC. WI. Dhrase. CIDENT WAS UNDERLY! RIBUTING CAUSE O. NOTIFY MEDICAL EX. FOF INJURY Month or a.m. p.m. artify that (I) (this deceased alive or any artify that (I) (This deceased alive or any artify that II) | DUE TO (b) DUE TO (c) IT CONDITIONS CO THE CONDI | ontributing to DEATH BUDGER arteriosclerot. ONTRIBUTING TO DEATH BUDGER ARTERIOSCO. DESCRIBE HOW INJURY OCCURRED 20a. A. INJURY OCCURRED 20a. | IC CARDIOVASCU T NOT RELATED TO THE TERM Clerosis without URED. (Entar nature of Injury PLACE OF INJURY (Home, for factory, street, office bldg., e) omnovember2, , , , , , , , , , , , , , , , , , | AINAL DISEASE COULT QUAL: In Part I or Part II Irm., 20f. (City tc.) 20f. (C | or town) comperment comperme | (County) 21,1962 and on the | Years 19. WAS AUTO PERFORME YES NO (Stete 1 that (I) (we) date stated ab 22b. DA 12/21/ 11e, Md. (State) |

MARYLAND STATE DEPARTMENT OF HEALTH

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FOR STATE HEALTH DEPT. funeral director. Page Principle of Your files. Mealth,

TO PUREAL DIRECTOR: Page 3 should be executed within 24 hours after death, any delay is please execute the cartificate, writing the word "pending" in pendil in Item 18, Give Peges 1, 2, and 3 sections of the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Boar or its destinanted attent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

its designated agent, prior to burist, cremation, or removal, and in any ever

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13807MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | 1 |
|--|----------------------------|--|---|--------------------|-------------------|--------------------|--------------------|----------------|--------------------|
| . PLACE OF DEATH | | | 2. USUAL RESIDEN | ICE (Whare da | | | sidence | before a | dmission) |
| Carroll | | MARYLAND | •. STATE Marvla | nd | b. COUN | itv | , | | |
| b. CITY OR TOWN (if outside | corporata limits, | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN | | | | giva nas | erast tow | n) |
| write RURAL and give na | arast town) | | | | | 2 | .10 | 1 11 | 1 |
| d. NAME OF HOSPITAL OR | NSTITUTION (if not in hor | 2yrs.5mos.8dy | d. STREET ADDRESS | ore 30 | | 2 | 40 | - 15 DE | CIDENICE |
| | | | | | | | 750 | | SIDENCE A FARM? |
| Springfield | d State Hosp | ital | 1302 T | owson | Street | | | YES 🔲 | NO GO |
| NAME OF DECEASED | First | Middle | Last | 4. DATE | Monti | 1 | Day | Yaar | |
| (Type or print) | Francès | Odell | Stare | DEATH | Decemb | er | 28 | 196 | 57 |
| 5. SEX 6. CO | LOR OR RACE 7. MARRIE | D NEVER MARRIED T 8 | B. DATE OF BIRTH | 19. | AGE (In yaers | IF UNDER 1 Y | | UNDER | |
| Female Wh: | Lte WIDOWE | | Tul- 10 100 | 1 | last birthday) | Months D | ays | Hours | Min. |
| 10a. USUAL OCCUPATION (Given | | IND OF BUSINESS OR INDUSTR | July 10, 190 | | 57 yrs. | 12 CITIZ | EN OF A | NUAT C | OUNTRY? |
| dona during most of working life | | IND OF BUSINESS OK INDUST | II. BINTIFEACE (Sidie | or foreign cou | miry) | 12. 0112 | EN OF | MHAIC | DUNIKIT |
| Housewife | | - | Maryla | .nd | | | U.S. | A. | |
| J. FATHER'S NAME | | | 14. MOTHER'S MAIDEN | NAME | | | | | |
| Charles Campl | pell | | Emma Har | ford | | | | | |
| MAS DECEASED EVER IN U. | | SOCIAL SECURITY NO. 17. | INFORMANT | | Address | | - | | |
| No No (Ifyasgiva | war of datas of servica) | · · | TI L. | | D | | | | |
| 18. CAUSE OF DEATH | Enter only one cause par l | | pringfield H | OSOITAL | necord | .5 | 1 INTER | VAL DET | NACES I |
| PART I. DEATH WAS | 1 | 7 57 | | 4 | | _ | | VAL BET | |
| IMMEDIA | TE CAUSE (a) | EURAL VAS | CKLHKI | recij | JENI | | - | | |
| 070 X | DUE TO | 56.4 | | 0 | - | 4 | | | |
| Conditions, if any, which | 1) (b) CET | TRAL NERVO | US JUSTE | in of h | PHIL | 15 | NE | A.R | 5 |
| gave rise to immediata caus | DUE TO | | | | | | 1 | | |
| (a), stating the undarlying causa last. | 00000 | | | | | | 10.00 | | |
| | CANT CONDITIONS CON | ITRIBUTING TO DEATH BUT NO | OT BELLATED TO THE TERM | NAL DISEASE | COMPITION | (FALINI DA DE 4 | 1 10 | | |
| | | | | | | | (a) 19. | WAS A PERFO | |
| Schizophrenic | ris cannot h | aranoid type. e <u>ruled out).</u> BE HOW INJURY OCCURED. (1 | Systemic Sy | burris | (Arrest | ea | YES | | NO X |
| general pares 20s. EXTERNAL CAUSE W/ PRIMARY or CONTRIBUT | S 20b. DESCR | IBE HOW INJURY OCCURED. (| Enter natura of injury In Pa | rt I or Part II of | item 18.) | | | | |
| CAUSE OF DEATH. | ING [] | | | | | | | | |
| 20c. TIME OF INJURY | Nonth, Day, Yeer 20d. | INJURY OCCURRED 200, PLA | CE OF INJURY (Homa, far | m. 1 20f. (City | or town) | (Count | hyl | , | (Steta) |
| Hour e.m. | While | Not While fact | lory, streat, office bldg., ato | | | (000 | , | , | Jidia) |
| p.m. | 19 at wor | k at work | | | | | | | |
| 21. I certify that I to | ok charge of the rem | ains described above, he | eld an Autopsy | Inspection | Inquir | y 😽 | and in | my of | oinion |
| death resulted from: | Natural causes | Accident , Suic | ide , Homicide | , Und | determined m | anner | | | |
| 1 // | n 51 | | CHIEF MEDICAL | EXAMINER [| | _ | | | |
| ACTUAL / | 12 1 11 | Loroh | ASSISTANT MED | DICAL EXAMINE | • 🗔 | | DAT | re sigi | NED |
| HIGNATURE | ccg | | M.D. | | | | | 1 3 | 1 |
| EXAMINER'S A | MEST MI | 1004 | DEPUTY MEDICA | _ | X Q | 11- | | 19 | 281 |
| 2a. BURIAL CHEMATION 776 | DATE THEREOF | VO LA | Addrass (Streat, | | ION (City, town | | LU | (Slate | 74 |
| REMOVAL (Specify) | - 16-1029 | 12 sus | - I | 120. LOCAT | A III | 2 country) | 1 | 1 4 | |
| 1 | 3 H - 2 HX | 1/1/ an | avonne | 0341 | Jall | mor | 1 | 10 | VI |
| 3. FUNERAL DIRECTOR | 1100 | ADDRESS | 1 /24a. RE | BY REGISTR | AR 24b. REG | ISTRAR'S SIG | NATURE | | |
| tranka | + 41011 | Ell Del | me 5 DATE J | M 5 '62 | 2 | wing & | 970000 | | |
| | | | | The second second | The second second | SCHOOL STREET, AND | THE REAL PROPERTY. | | |

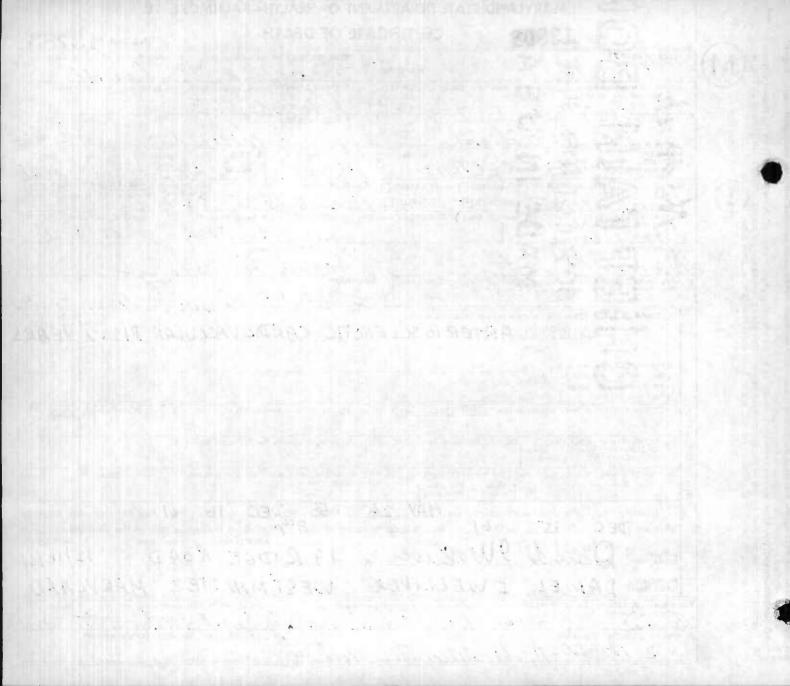
ECCOPANDICAL EXAMINERS CONTRACTOR OF HEATH AND THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS The second to the second second second second (2:10:56:11) SATING MELTING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13808 CERTIFICATE OF DEATH

Reg. Dist. No. 3783

| 1 | 1. PLACE OF DEATH | A DE LA RES | 2. USUAL RESIDENCE (Where deceased lived. | If institution: Residence before admission) |
|---|---|---------------------------|--|--|
| Ţ | a. COUNTY | MARYLAND | a_STATE | COUNTY CALL |
| | b. CITY OR TOWN (If autside carporate limits, write | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If autside carporate lin | nits write RITRAL and give negrest town |
| | RURAL and give nearest tawa) | 5000 | 10.11. | 2 7 |
| | Mes pisselle | 30 glarat | Mammaler | o del |
|) | d. NAME OF HOSPITAL (If nat in haspital, give street of INSTITUTION | (ddress) | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| | Jardans Mest Hor | ne | 155 W. Mese | YES NO D |
| | NAME OF First | Middle | Last 4. DATE | Manth Day Year |
| | Type or print) IOWA CEC | CILIA ST | TARNER DEATH | DEC. 16 1961 |
| | S. SE 6. COLOR OR RACE 7. MARRI | ED NEVER MARRIED | 8. DATE OF BIRTH 9. AG | E (In years IF UNDER 1 YEAR IF UNDER 24 HRS. |
| | temale White WIDOWE | | Nec. 15/875/8 | birthday) Manths Days Haurs Min. |
| | USUAL OCCUPATION (Give kind af wark dane 10b. k | CIND OF BUSINESS OR INDUS | TRY 11. BIRTHPLACE (State ar fareign country) | 12. CITIZEN OF WHAT COUNTRY? |
| | Mans 1 - Coyse - | | Carrollo m | d. U.S.D. |
| | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| | Deril PP+ | | Car 1 21 71 | |
| | Warra It, letres | | Jaran H. go | Trung |
| | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 15. S | OCIAL SECURITY NO. | NFORMANT | Address |
| | | - m | 2 Kalen H. Stan | 11 Whotnesset my |
| | 18. CAUSE OF DEATH [Enter anly ane cause per line | e far (a), (b), and (c).] | , layer | INTERVAL BETWEEN |
| | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AR- | TERIOSCIE! | ROTIC CARDIOVASC | ULAR DIS 19 YEARS |
| | 4221 DUE TO | 1510 10 10 1 | TOTTE CONTROL OF THE | VEAR DIST LINES |
| | 17.31 | | | |
| | Canditians, if any, which (b) | | | |
| | cause (a), stating the <u>under-</u> DUE TO | | | |
| | lying couse last. (c) | | | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CO | ONTRIBUTING TO DEATH BUT | NOT RELATED TO THE TERMINAL DISEASE CONT | DITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
| | [5] | | | YES NO |
| | PART II. OTHER SIGNIFICANT CONDITIONS CO | RIBE HOW INJURY OCCURRED |). (Enter nature af injury in Part I ar Part II af i | tem 18.) |
| | | | | |
| | 20c. TIME OF INJURY Manth, Day, Year 20d. IN | JURY OCCURRED 20e. PLA | CE OF INJURY (Hame, farm, 20f. (City ar taw | rn) (Caunty) (State) |
| | 20c. TIME OF INJURY Manth, Day, Year 20d. IN While p. m. 19 at wark | Nat while fac | tary, street, affice bldg., etc.) | |
| | | 44.014 - 4 | 10 . DEC 11 | /1 |
| | 21. I certify that I attended the decease | | 1930, to DEC 16 | , 1961, that I last saw the deceased |
| | alive an DEC 15 , 196 | $I_{}$, and that death | • | auses and an the date stated abave. |
| П | - 10 11 | 1.00 0 | ADDRESS (Street, ci | ty ar tawn, state) DATE SIGNED |
| | SIGNATURE James 9 U | relewer, | A.D. 19 KIDGE K | OAD 12/16/61 |
| | PHYSICIAN'S DALLEL - | 1 1 . 11 | | - n la h l |
| | NAME (Type) DANIEL IV | NELLIVER | WESTMINST | EL MARYLAND |
| ١ | 22a. BURIAL, CREMATION, 22b. DATE THEREOF, | 22c. NAME OF CEMETERY OF | | ity, tawn, or caunty) (State) |
| | REMOVAL (Specify) 12/20/6/ | Bent Chan | al Resoluce Report | Interiorita no |
| | 23. FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 24a. REC'D BY REGISTRAR | 24b, REGISTRAR'S SIGNATURE |
| 6 | 4-5-mallo by land | tones its | 20 | AND REGISTRANT STOTIATORE |
| | 4 5 1,000 1 1 1016 | 211mmoul | DATE 22 161 | 75. 9 Km |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12000 CERTIFICATE OF DEATH
12784 13809

13784

| 1 | PLACE OF DEATH o. COUNTY | 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before admission) | | | | |
|---------------|---|---|--|--|--|--|
| M | Carroll MARYLAND | Maryland Balto. | | | | |
| /- | b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) | | | | |
| | write RURAL and give nearest town) | | | | | |
| - | SVKesville | Baltimore d. STREET ADDRESS 1. IS RESIDENCE | | | | |
| 1 | d. NAME OF HOSPITAL OR INSTITUTION (if not In hospitel, give sfreet eddress) | d. STREET ADDRESS 6. IS RESIDENCE ON A FARM? | | | | |
| 7 | Sminafield State Meanitel | 1777 C Tandon Arra | | | | |
| 3 | Swringfield State Hospital Middle | 1718 Linden Ave. | | | | |
| | Type or print) | OF DEATH 10 | | | | |
| - | Josephine B. S | Stone December 9 7 61 | | | | |
| l ° | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. | DATE OF BIRTH 9. AGE (In years IT UNDER 1 YEAR IT UNDER 24 FRS. last birthday) Months Days Hours Min. | | | | |
| VI. | Formale White WIDOWED DIVORCED : | July 26, 1868 93 m | | | | |
|) [1 | Da. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | Y 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 1 | lone during most of working life, even if retired) | | | | | |
| - | Milliner Milliner | Balto. Maryland U. S. A. | | | | |
| 1. | 3. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | | | |
| | Carlos Bouchet | Unknown | | | | |
| | | NFORMANT Address (Records) | | | | |
| (| (es, no, or unkown) (If yes give wer or detes of service) | | | | | |
| = | None S 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] | pringfield State Hospital Sykesville Md. | | | | |
| | PART I. DEATH WAS CAUSED BY: | ONSET AND DEATH | | | | |
| | IMMEDIATE CAUSE (e) Cardiac Insui | fficiency (Decompensation) years | | | | |
| | LL 2 LA GUETO | | | | | |
| | | | | | | |
| | gave rise to immediate cause | | | | | |
| | (a), stating the underlying DUE TO | | | | | |
| | causa last. (c) | | | | | |
| 2 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED? | | | | |
| CEPTIFICATION | Monda damagadama asaaddaa | YES NO THE | | | | |
| - La | Manic depressivee reaction. 20e. Accident was underlying it is 20b. Describe HOW INJURY OCCURED. | (Enter nature of injury in Pert I or Pert II of item 18.) | | | | |
| FDT | OR CONTRIBUTING CAUSE OF DEATH | (chief indicate of infair) in fair it of fair it of fair it of | | | | |
| - 1 | | | | | | |
| WEDICAL | 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, ferm, 20f. (City or town) (County) (State) ory, street, office bldg., etc.) | | | | |
| AF. | Hour e.m. While Not While tack | ory, sites, office bidg., etc.) | | | | |
| 1 | | | | | | |
| | | July 7 1914, to Becember 919.61 that (I) (we) last | | | | |
| | saw the deceased alive onDec | death occured at 1.2 M, from the causes and on the date stated above. | | | | |
| | 22a. SIGNATURE | 22b. DATE | | | | |
| | Many D. Prentunda | D ATTENDING MED. STAFF PHYS. IX Dec. 9, 196 | | | | |
| | 22s. PHYSICIAN'S | 22d. ADDRESS | | | | |
| | NAME (Type) Naci N. Buyukunsal, M.D. | Sykesville, Maryland | | | | |
| - | | | | | | |
| 12 | Sa. BURIAL CREMATION 236. DATE THEREOF 230 NAME OF CEMETERY C | DE CREMATORY 23d. LOCATION (City, town or county) (Steta) | | | | |
| | Burial 12-16-61 wring No | Theloville, ma. | | | | |
| 2 | FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE | | | | |
| 10 | testing I Apricht Supposelling | DATE DEC 1 9'61 Crithun S. Kraus | | | | |
| do | willing it willing it is in the | 1 | | | | |

OF VR A15:(4) 15M 7/61

THE RESERVE THE PARTY OF THE PA A PARTY OF PURISH STORY OF THE William of the Manual In The State of the St 1 Items 18821 Film 305 MARYLAND STATE DEPARTMENT OF HEALTH

| X | | Divisio |
|--|---------------|---|
| FOR STATE | | |
| HEALTH DEPT. | 1. | PLACE OF DEA |
| od or Pa | | b. CITY OR TOW write RURAL |
| delay is eral dim of for y | | d. NAME OF HO |
| retains he Stat r death | 3. | NAME OF DECEASED (Typa or print) |
| death nd 3 is 2 with 2 | Ш | sex fale |
| 7.50 | 10a do | LUSUAL OCCUP no during most of Farm Han |
| 24 hou Pages M3. P pages within | 13. | FATHER'S NAM |
| CA D. C. | 4.5 | Harry S |
| 18. 18. 18. 18. 18. 18. 18. 18. 18. 18. | 15. (Ye | WAS DECEASED os, no, or unkown) No |
| executed in Item ong with nit pern | | 18. CAUSE O |
| d be exect pencil in ice along ial-transit ald, and in | | 322 |
| ate should be ding" in pen iner's Office I as a burial-h or removal, s | | Conditions, if |
| ifficate sho pending" aminer's (ised as a b on, or rem | | geve rise to imn (e), stating the |
| ertificate d'pendin Examiner's e used as stion, or r | z | PART II. OT |
| This certific word "per dical Examuld be used cremation; | ATIO | 171111111111111111111111111111111111111 |
| 9 0 0 ~ | CERTIFICATION | 20a. EXTERNAL PRIMARY ☐ or CAUSE OF DEA |
| AMINER writing the Chief M Page 3 sh | MEDICAL | 20c. TIME OF II |
| cate, v to the OR: Pa prior t | ME | р. |
| IEDICAL EX. The certificate, rwarded to the DIRECTOR: bd agent, prior | | 21. I certify death resulte |
| DICAI e certifi arded IRECT agent, | | deam resume |
| PUTY MEDICA, execute the certifuld be forwarded NERAL DIRECT designated agent, | | ACTUAL SIGNATURE |
| EPUTY Me execute ould be for JNERAL I designate | | EXAMINER'S NAME (Type) |
| Sho Sho | 224 | REMOVAL (Spe |
| 5 g 4 b g | 23 | Buria1 |
| VS. A15ME | 1 | Richard |

| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE | E (Where d | eceesed lived, If | Institution: Re | esidence be | fore edinission |
|---|--|---|--|---|--|--|--|----------------------|--|---|
| COUNTY | rroll | | MARYLA | CHYD | a. STATE | land | b. COUN | | mmol 1 | |
| | outsida corporate limit | ts, | c. LENGTH OF STAY | | e. CITY OR TOWN (I | | orate limits, write | | rrol | |
| write RURAL end | give nearest town) | | | | ./ | | | | | |
| d. NAME OF HOSPIT | lver Run | f not in he | spital, give straat address | 3 | d. STREET ADDRESS | ninste | <u>r</u> | | 1.0 | IS RESIDENCE |
| | | | opinal, givo andar address | | a. o.keel Abokeos | | | | | ON A FARM? |
| NAME OF | ir's Inn | | 11/2/0 | | Rt. | | 14 | | | S NO |
| DECEASED | First | | Middle | | Last | 4. DATE OF | Month | 1 | Dey | Yeer |
| (Typa or print) | CLET | | HARRY | | STONESIFER | DEATH | Decen | | 31 | 19 61 |
| I. SEX | 6. COLOR OR RACE | 7. MARRI | ED NEVER MARRIED | * 8. | DATE OF BIRTH | 9 | . AGE (In years last birthdey) | | | NDER 24 HRS. |
| Male | White | WIDOW | ED DIVORCED | $\exists \mid j$ | an. 30, 1919 | | 1.2 Yrs. | Monins | 76 A2 110 | urs Min. |
| Oa. USUAL OCCUPATION done during most of wor | | | KIND OF BUSINESS OR IN | | | | untry) | 12. CITIZ | ZEN OF WI | HAT COUNTRY |
| Farm Hand | king lite, evan it relite | | arming | | Carroll Co. | . Md. | | U.S | .A. | |
| . FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN | | | | | |
| Harry Sto | nesifer | | | | Gertie St | onesi | fer | | | |
| 5. WAS DECEASED EVE | R IN U.S. ARMED FOR | CES? 16 | SOCIAL SECURITY NO. | 17. X | NFORMANT | | Address | | | |
| Yes, no, or unkown) (If | yes give wer or detes of se | | 216-16-1935 | Meso | . Gertie Sto | nacif | ar Most | minata | m Ma | D A |
| | work to | 1 | 70-10-1222 | 2.77 | of octate of |)IIC SIL | r, mest | INTII2 CG | | |
| IO. CAUSE OF D | | | line for (a) (b) and (a) 1 | | | | | | I INTERNAL | A DETLIFERA |
| | | cause per | line for (e), (b), end (c).] | | | | | | ONSET | AND DEATH |
| PART I. DEATH | WAS CAUSED BY: MMEDIATE CAUSE (a)_ | cause per | | | Intoxicati | on | | | ONSET | AND DEATH |
| PART I. DEATH | WAS CAUSED BY: | cause per | | | Intoxicati | on | | | ONSET | AL BETWEEN AND DEATH |
| PART I. DEATH 322, Conditions, if eny | WAS CAUSED BY: WMEDIATE CAUSE (a) DUE TO Which (b) | cause per | | | Intoxicati | on | | | INTERVA | AL BETWEEN AND DEATH |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia | WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO Which te cause | cause per | | | LIntoxicati | on | | | INTERVA | AL BETWEEN |
| PART I. DEATH 3 2 2, 6 Conditions, if eny | WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO which te cause derlying DUE TO | cause per | | | LIntoxicati | on | | | INTERV | AL BETWEEN AND DEATH |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), steting the un cause lest. | WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO which te cause denlying DUE TO (c) | | Ethyl Alco | ohol | L Intoxicat | | CONDITION GIV | /EN IN PART | ONSET | AND DEATH |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), steting the un cause lest. | WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO which te cause denlying DUE TO (c) | | Ethyl Alco | ohol | | | CONDITION GIV | VEN IN PART | ONSET | AND DEATH /AS AUTOPSY PERFORMED? |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), steting the uncause lest. | WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO Which te cause derlying DUE TO (c) SIGNIFICANT CONDIT | поиз <u>со</u> | Ethyl Alco | ohol | T RELATED TO THE TERMIN | IAL DISEASE | | /EN IN PART | ONSET | AND DEATH /AS AUTOPSY PERFORMED? |
| PART I. DEATH 3 2 2 , Conditions, if eny, geve rise to immedia (e), stetling the un cause lest. | WAS CAUSED BY: MMEDIATE CAUSE (a) DUE TO which te cause derlying SIGNIFICANT CONDIT USE WAS 2 | поиз <u>со</u> | Ethyl Alco | ohol | | IAL DISEASE | | EN IN PART | ONSET | AND DEATH |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), stelling the un cause lest. PART II. OTHER 20e. EXTERNAL CA PRIMARY Or COL CAUSE OF DEATH. | WAS CAUSED BY: WMEDIATE CAUSE (a) DUE TO Which to cause derlying DUE TO (c) SIGNIFICANT CONDIT USE WAS ATRIBUTING | TIONS <u>CO</u> | Ethyl Alco | BUT NO | T RELATED TO THE TERMIN nter nature of injury In Part | I or Pert II of | f item 18.) | | ONSET | /AS AUTOPSY PERFORMED? |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), steting the uncause lest. PART II. OTHER 20s. EXTERNAL CAPRIMARY or COL CAUSE OF DEATH. | WAS CAUSED BY: WMEDIATE CAUSE (a) DUE TO Which to cause derlying DUE TO (c) SIGNIFICANT CONDIT USE WAS ATRIBUTING | TIONS <u>CO</u> | Ethyl Alco | BUT NO | T RELATED TO THE TERMIN | I or Pert II of | | /EN IN PART (Coun | ONSET | AND DEATH |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), stelling the un cause lest. PART II. OTHER 20e. EXTERNAL CA PRIMARY Or COL CAUSE OF DEATH. | WAS CAUSED BY: WMEDIATE CAUSE (a) DUE TO Which to cause derlying DUE TO (c) SIGNIFICANT CONDIT USE WAS ATRIBUTING | TIONS CO | Ethyl Alco | BUT NO | T RELATED TO THE TERMIN nter nature of injury In Part CE OF INJURY (Home, farm | I or Pert II of | f item 18.) | | ONSET | /AS AUTOPSY PERFORMED? |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), stelling the un cause lest. PART II. OTHER 20e. EXTERNAL CA PRIMARY Or COL CAUSE OF DEATH. 20c. TIME OF INJUI Hour a.m. p.m. | WAS CAUSED BY: MARDIATE CAUSE (a) DUE TO Which te cause derlying DUE TO (c) SIGNIFICANT CONDIT USE WAS ATRIBUTING Y Month, Dey, Yee | Ob. DESCI | Ethyl Alco | BUT NO JRED. (E | T RELATED TO THE TERMIN nter nature of injury In Part CE OF INJURY (Home, farm try, street, office bldg., atc. | I or Pert II of | f item 18.} | (Coun | ONSET 1(e) 19. W | /AS AUTOPSY PERFORMED? |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), stelling the un cause lest. PART II. OTHER 20e. EXTERNAL CA PRIMARY Or COI CAUSE OF DEATH. 20c. TIME OF INJUI Hour a.m. p.m. | WAS CAUSED BY: MARDIATE CAUSE (a) DUE TO Which to cause derlying DUE TO (c) SIGNIFICANT CONDIT USE WAS NTRIBUTING 19 at I took charge of | ob. DESCI | Ethyl Alco | BUT NO JRED. (E | T RELATED TO THE TERMIN nter nature of injury In Part CE OF INJURY (Home, farm nry, street, office bldg., atc. | I or Pert II of | f item 18.} | (Coun | ONSET 1(e) 19. W | AND DEATH VAS AUTOPSY PERFORMED? NO (Stete) |
| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), steling the un cause lest. PART II. OTHER 20e. EXTERNAL CA PRIMARY or COI CAUSE OF DEATH. 20c. TIME OF INJUI Hour a.m. p.m. 21. I certify th | WAS CAUSED BY: MARDIATE CAUSE (a) DUE TO Which to cause derlying DUE TO (c) SIGNIFICANT CONDIT USE WAS NTRIBUTING 19 at 1 took charge of | ob. DESCI | Ethyl Alco | BUT NO JRED. (E Oe. PLA fecto ve, hel | T RELATED TO THE TERMIN nter nature of injury In Part CE OF INJURY (Home, farm nry, street, office bldg., atc. | I or Pert II of | y or town) | (Coun | ONSET 1(e) 19. W | AND DEATH VAS AUTOPSY PERFORMED? NO (Stete) |
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| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), stetling the uncause lest. PART II. OTHER 20a. EXTERNAL CAPRIMARY or COI CAUSE OF DEATH. 20c. TIME OF INJUIT Hour a.m., p.m. 21. I certify the death resulted for ACTUAL SIGNATURE EXAMINER'S NAME (Type) 2a. BURIAL, CREMATIO REMOVAL (Specify) | WAS CAUSED BY: MARDIATE CAUSE (a) DUE TO Which to cause derlying DUE TO SIGNIFICANT CONDIT USE WAS NATRIBUTING Y Month, Dey, Yee 19 at I took charge of the common commo | ob. DESCIONS CO Ob. DESCI While wo of the rei uses Pet | Ethyl Alco | BUT NO JRED. (E Oe. PLACE fecto Ve, hel Suici | T RELATED TO THE TERMIN THE NAME OF THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE THE TERMIN THE TERMI | IAL DISEASE I or Pert II of , 20f. (Cit-) Inspection LON XAMINER CAL EXAMINE EXAMINER ity, town, or 22d. LOCA | y or town) y or town) logical property of the property of th | (Coun | ONSET 1(e) 19. W YES ty) DATE 12/ | (Stete) (State) |
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| PART I. DEATH 3 2 2, Conditions, if eny, geve rise to immedia (e), steling the uncause lest. PART II. OTHER 20a. EXTERNAL CAPRIMARY or COI CAUSE OF DEATH. 20c. TIME OF INJUIT Hour a.m. p.m. 21. I certify the death resulted finance of the condition of the | WAS CAUSED BY: MARDIATE CAUSE (a) DUE TO Which to cause derlying DUE TO SIGNIFICANT CONDIT USE WAS NATRIBUTING Y Month, Dey, Yee 19 at I took charge of the common commo | ob. DESCIONS CO Ob. DESCI While two of the rei uses Pet | Ethyl Alco | Ohol BUT NO URED. (E Oe. PLAG fecto Ve, hel Suici | T RELATED TO THE TERMIN THE NAME OF THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE TERMIN THE THE TERMIN THE TERMI | IAL DISEASE I or Pert II of 20f. (Cit- inspection Inspection CAL EXAMINER EXAMINER EXAMINER ity, town, or 22d, LOCA D BY REGIST | y or town) y or town) y or town) determined m ler county) TION (City, town estminsi RAR 246. REG | (Country) | ONSET 1(e) 19. W YES ATTOL: GNATURE | (Stete) (State) |

Horica ma strike ster you want Lionar The tarted thes. Combine Standards, see the tarte 1/00/21 care during Company or Petropy or It. of them with the state of the s Productive in the second strain White hand of which is

24 FUNERAL DIRECTOR'S SIGNATURE
HOVER MC COMES

| | | | | YLAND STATE D | EPARTMENT (| OF HEALT | Н | -30=1 | | | |
|---------------|---|---|-----------------------|--|--|----------------------|---------------------------|---------------|---------------------|--|--|
| | | OF STATISTI | CAL RESEA | CERTIFICA | S, 301 W. PREST TE OF DEAT | | BALTIMORE | I, MAR | YLAND | | |
| _ | | | | O I KI I I I I I I I I I I I I I I I I I | | | | 124 | 70C | | |
| 1. | PLACE OF DEAT a. COUNTY | Н | | | 2. USUAL RESIDEN | ICE (Where dece | | n: Andend | 6 Seton dynission) | | |
| | Carroll | | | MARYLAND | e. STATE | rland | b. COUNTY | rford | V | | |
| | b. CITY OR TOWN | (if outside corporate d give nearest town) | limits, | c. LENGTH OF STAY IN 16 | | | te limits, write RURAL | | | | |
| | d. NAME OF HOSP | 111e | N (if not in hos | 3 days | Edgewood d. STREET ADDRESS | | 13 | ZX. | 2 . IS RESIDENCE | | |
| | | eld State | | | | 3ox 23 | | | ON A FARM? YES X NO | | |
| 3. | NAME OF | | irst | Middle | Last | 4. DATE | Month | Day | Yeer | | |
| | DECEASED (Type or print) | Clvde | | Vernon | Tibbs | OF DEATH | December | 23 | 1961 | | |
| 5. | SEX | | CE I | | . DATE OF BIRTH | 1 | | | IF UNDER 24 HRS. | | |
| | Male | White | 7. MARRIEI | THE | 8-9-1896 | | GE (In years of UND Month | | Hours Min. | | |
| 10a | s. USUAL OCCUPA | TION (Give kind of working life, even if re | vork 10b. KI | ND OF BUSINESS OR INDUSTR | | nty & State, or for | 77 | CITIZEN OF | WHAT COUNTRY? | | |
| | - | Shipvard | | | Virgini | 0 | | U.S.A | | | |
| 13. | FATHER'S NAME | outpland | MOTW | | 14. MOTHER'S MAIDEN | | | 0.000 | — | | |
| | John Tib | bs | | | Unknown | | | | Your | | |
| 15. | | ER IN U.S. ARMED F | ORCES? 16. | SOCIAL SECURITY NO 17. I | NFORMANT | Bell | Address | | | | |
| (Ye | s, no, or unkown) (| lfyes give wer or dates | ofservice) | 17-16-3459 | | Industrial | | | | | |
| U | nknown | | | | pringfield H | Capter | necords | | | | |
| | | | | ne for (a), (b), and (c).] | | | | | RVAL BETWEEN | | |
| | PART I. DEAT | H WAS CAUSED BY | (a) Far | advanced pulmo | nary tuberc | ulosis | | | ears | | |
| | 00 | J X DUE | | | | | | | 0 00.2 10 | | |
| | Conditions, if an | | - | eriosclerotic h | and diamen | | | | | | |
| | gave risa to immed | liate causa | | Prioscieroule (| lear of disease | е. | | y | ears | | |
| | (e), stating the | anderlying DUE | 10 | | | | | | | | |
| | cause last. | | (c) | | | | | | | | |
| NO | PART II. OTHE | R SIGNIFICANT CON | IDITIONS CON | TRIBUTING TO DEATH BUT NO | T RELATED TO THE TERMI | NAL DISEASE CO | NDITION GIVEN IN P. | ART 1(a) 19 | . WAS AUTOPSY | | |
| ATI | ape a | | | | | | | Y | PERFORMED? | | |
| FIC | 20a. ACCIDENT W | ue to arte | | CRIBE HOW INJURY OCCURED | (Enter nature of injury in | Part I or Part II of | item 18) | 1 | | | |
| CERTIFICATION | OR CONTRIBUTING | MEDICAL EXAMIN | TH | THE THE THE PROPERTY OF COME | temer nature of injury in | 7011 7 01 1011 11 01 | 110111 101, | | | | |
| | | | 1 | | | | | | | | |
| MEDICAL | 20c. TIME OF INJU | JRY Month, Day, | Year 20d. II While | NJURY OCCURRED 20e. PLA | CE OF INJURY (Home, farr ory, street, office bldg., etc | m, 20f. (City or | town) (0 | County) | (Steta) | | |
| MED | p.m. | 15 | 2.4 | | | 1 | | | | | |
| | 21 cortify | that (1) (this hos | nital) attend | led the deceased from | 12-20- | 1967 to 7 | 2-23 | 10 67 11 | at (1) (wa) last | | |
| | | sed alive on1 | | 19. 61, and thet | | | | | | | |
| | 22e. SIGNATURE | sed allve OilL | fra Armad | 17 | deam occured ar | wi, 'ifom ii | ie causes and o | n me dai | 22b. DATE | | |
| | 226. SIGNATURE | 1 | 0/0/1 | Acres 6. | | MED. | STAFF | | SIGNED | | |
| | Nigo | with | CKI | CARRY M. | D | DIRECTOR | PHYS. | | 12/23/61 | | |
| | 224 PHYSICYAN'S NAME (Type |) | 2 2 2 | 1/6/ | 22d. ADDRESS | -14 C+-+ | Hognital | Sarke | esvillem N | | |
| | 17 | Agustin | del Cam | po, M.V. | Springile | ata prare | Hospital | , Dyke | SOATTTON'S L | | |
| 234 | BURIAL, CREMAT | ION, 23b. DATE T | HEREOF | 23c. NAME OF CEMETERY | OR CREMATORY | 23d. LOCATI | ON (City, town or co | unty) | (State) | | |
| | Burial Dec. 27,1961 Bel Air Memorial Gardens Bel Air, Harford, Maryland | | | | | | | | | | |

Abingdon Maryland.

DATE

25b. REGISTRAR'S SIGNATURE

15M 7/61

Belle Cox the property of the second and the s and the control of th Bittl Duc. 2, 1951 But Ir Amerika Cerdens Bol Mir, Mart was 11 y 12 Dillion Miglic. LUTE COMES MARYLAND STATE DEPARTMENT OF HEALTH

| | | 2 | | |
|-------------------------|-----------------------|----------------|-------------------------|--------|
| DIVISION OF STATISTICAL | RESEARCH AND RECORDS, | 301 W. PRESTON | STREET, BALTIMORE 1, MA | RYLAND |
| 13812 | CERTIFICATE | OF DEATH | 137 | 81 |

| | Carroll | | MARYLAND | a. STATE Mar | yland | b. COUNT | | City | dmisnon | |
|-------------------|--|---|--------------------------------------|--|---------------------------------|-----------------|----------------|----------------------|----------|--|
| Ь | o. CITY OR TOWN (if write RURAL and, Sykesvi | outside corporate limits, | 1 ma. 7days | e. city or town Baltimo | (If outside corporate ore 12 | limits, write l | RURAL end give | neerest tow | (n) 4 | |
| d | | ield State Hosp | | d. STREET ADDRESS 704 E. | Coldspri | ng Lar | ne | e. IS R ON YES | A FARM? | |
| 1 | NAME OF DECEASED Type or print) | | wman Twedd | last | 4. DATE OF DEATH 1 | 2/31/ | De | | 61 | |
| 5. | Male | 6. COLOR OR RACE 7. MARRIE WIDOWE | | 5/7/ 1883 | | | Months Days | Hours | Min. | |
| 10a. don Sa | USUAL OCCUPATION Advisor OF CHEST CONTROL OF CHEST CONTRO | | IND OF BUSINESS OR INDUSTR | Baltimore | | yland | U.S. | | OUNTRY? | |
| 13. | John Twe | ddle | | Jennie? | NAME | | | | | |
| 1S. (Yes | WAS DECEASED EVE | R IN U.S. ARMED FORCES? ves give wer or defes of service) | | pringfield H | Hospital R | Address | | | | |
| NON | PART I. DEATH Conditions, if eny, geve rise to immedie (e), stelling the un ceuse last. PART II. OTHER | which to couse derlying DUE TO (c) SIGNIFICANT CONDITIONS CON | te Myocardial cumonia, Left lo | over lobe | nal disease cond | DITION GIVE | C | | DEATH | |
| 2 | C.B.S. due to Generalized Arteriosclerosis 20. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20. ACCIDENT WAS UNDERLYING ACCIDENT WAS UNDERLYING FOR CONTRIBUTING ACCIDENT MEDICAL EXAMINER. | | | | | | | | | |
| MEDICAL | 20c. TIME OF INJUR Hour a.m. p.m. | Y Month, Dey, Yeer 20d. While 19 et wor | Not While fac | CE OF INJURY (Home, far lory, street, office bldg., etc | | own) | (County) | | (Stete) | |
| | 21. I certify that (I) (this hospital) attended the deceased from | | | | | | | | | |
| 1 | 22e. SIGNATURE | the del 6 | lempo. " | | | TAFF HYS. | | 22b | SIGNED, | |
| B1 24 | BURIAL, CREMATIC REMOVAL (Specify) 1P181 FUNERAL DIRECTOR' W.JONKII | | Greenmount Of York Road To 12, Md. | Cometery 25s. RE | C'D BY REGISTRAR | imore | , Mary | land | tate) | |

and control filled in by the funeral control, papers. Pages 1 and 2 should it, within 72 hours after death. ruted within 24 hours after TO SOPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exercised. Page 4 may be retained by the hospital or attending physician.

Yes TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and construction and construct

AND REPORT OF THE PARTY OF THE BIT THE PERSON AS A SECOND MY ALCO NO STREET DISCOUNTY and support and the support of the s to the first of the state of th

VR A15 (4) 15M 9/60 15

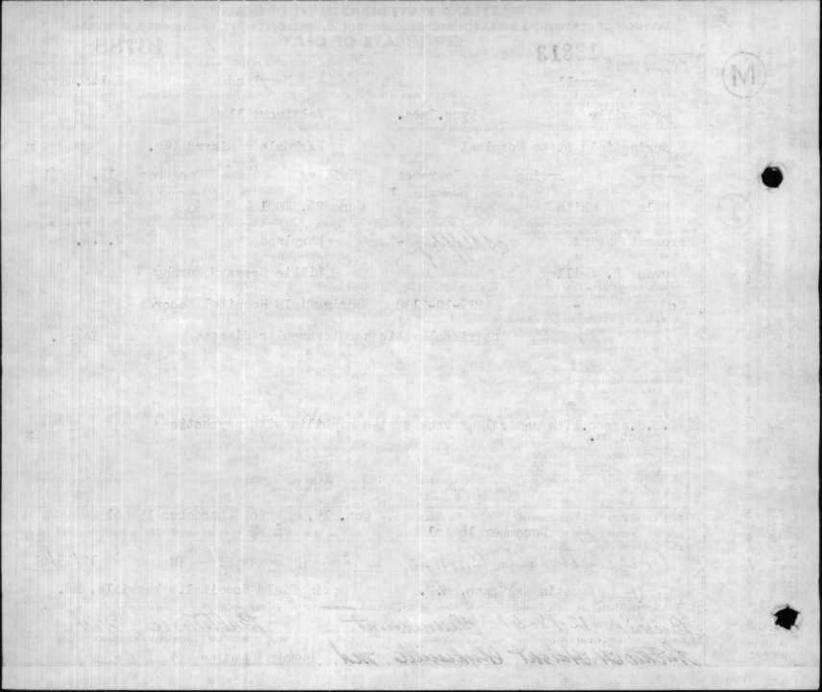
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13788

| 1. | 1. PLACE OF DEATH e. COUNTY | | | 2. USUAL RESIDENCE (Where decessed lived, If Institutions Residence before edmission | | | | |
|---------------|---------------------------------------|---|---|--|--|--|--|--|
| | | Carroll | MARYLAND | * STATE Maryland b. COUNTY Balto. City | | | | |
| Т | b. CITY OR TOWN (I | foutsida corporete limits, | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give naerest town) | | | | |
| | write RURAL and | giva neerest town) | 4. | | | | | |
| | Sykesvi | | 5yrs • 2mos • In hospital, give street address) | Baltimore 11 3/01-4 | | | | |
| | | ield State Ho | | Parkdale & Girard Ave. | | | | |
| 3. | NAME OF | First | Middle | Last 4. DATE Month Dey Year | | | | |
| | DECEASED (Type or print) | Irving | Lawrence | Twilley December 15, 19 61 | | | | |
| 5. | SEX | 6. COLOR OR RACE 7. M | ARRIED NEVER MARRIED 8 | DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. | | | | |
| | Male | 7.71 | OWED DIVORCED | June 26, 1901 last birthdey) Months Days Hours Min. | | | | |
| 10a | one during most of wor | ON (Give kind of work king life, even if retired) | Ob. KIND OF BUSINESS OR INDUSTR | | | | | |
| 1 | Merchant Ma | rine | Shiffing - | Maryland U.S.A. | | | | |
| 13. | FATHER'S NAME | | 11/ | 14. MOTHER'S MAIDEN NAME | | | | |
| | Irving L. | | | Lillie Cassard Murphy | | | | |
| 15. | WAS DECEASED EVE | R IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 17. 1 | NFORMANT Address | | | | |
| 100 | No. | yas give war or dates of sarvice) | 215-10-2130 | Springfield Hospital Records | | | | |
| | 18. CAUSE OF D | EATH [Enter only one cause | per lina for (a), (b), and (c).) | INTERVAL BETWEEN | | | | |
| | | MAS CAUSED BY: | Arteriosclerotic | cardiovascular disease ONSET AND DEATH Years. | | | | |
| | 4700 | DUE TO | | | | | | |
| | Conditions, if any, | which (b) | | | | | | |
| | gave risa to Immadia | ita causa | | | | | | |
| | (a), stating tha un | darlying | | | | | | |
| ~ | ceuse last. |) (c) | CONTRIBUTING TO STATE | | | | | |
| CERTIFICATION | C.B.S.ass | | ral nervous syste | or related to the terminal disease condition given in part 1(a) 19. Was autopsy em syphilis with psychotic performed? YES \[NO] | | | | |
| CERTIFI | | AS UNDERLYING 20b. CAUSE OF DEATH MEDICAL EXAMINER) | DESCRIBE HOW INJURY OCCURED | . (Enter neture of injury in Pert I or Part II of Item 18.) | | | | |
| Y | 20c, TIME OF INJUR | RY Month, Day, Yeer | 20d. INJURY OCCURRED 20e. PLA | CE OF INJURY (Home, ferm, † 20f. (City or town) (County) (State) | | | | |
| MEDICAL | Hour a.m. p.m. | | While Not While fect | ory, street, office bldg., etc.) | | | | |
| | 21. I certify th | nat (I) (this hospital) a | attended the deceased from | Oct. 15, 1956, to December 1519.61 that (I) (we) las | | | | |
| | | | | death occured at | | | | |
| | 22a. SIGNATURE | 1 | 20 | 22b. DATE | | | | |
| | Cloud | ustin de | l'Campo m | D. ATTENDING MED. STAFF PHYS. 12/15/61 | | | | |
| | 22c. PHYSICIAN'S NAME (Type) | | | 22d. ADDRESS | | | | |
| | HAME Gabet | Agustin del | Campo, W.D. | Springfield Hospital, Sykesville, Md. | | | | |
| 23 | BURIAL, CREMATIC REMOVAL (Specify) | DN, 236. DATE THEREOF | 23c. NAME OF CEMETERY OF | OR CHARGEY 23d. LOCATION (City, fown or county) (Stale) | | | | |
| 24 | FUNERAL DIRECTOR | 10 0 | ADDRESS | 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE | | | | |
| 1 | Suffing 9 | W Haralt | Aufuille. | DATEDEC 1 9'61 Outhor & Kroup | | | | |
| 6 | 10000 | 100100 | Callen Comment | The state of the s | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

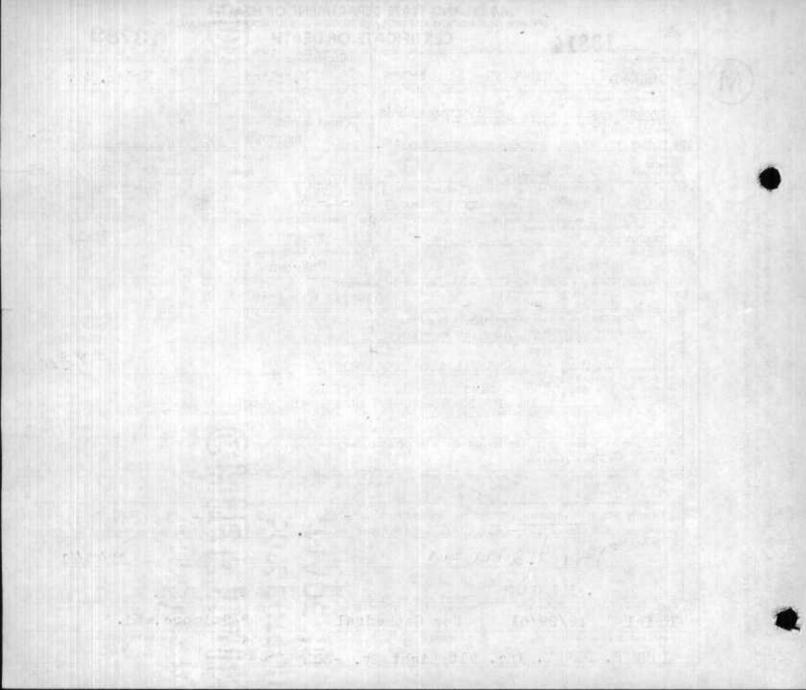
CERTIFICATE OF DEATH 13814 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNT g. STATE b. COUNTY MARYLAND MARYLAND Marvland Balto City CARROLL b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) BALTIMORE SYKESVITTE I 194 7Wks 29da d. NAME OF HOSPITAL (If not in haspital, give street address) e. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? nyknowy YES NO DO SPRINGETEID Edmondson STATE HOSPT SYKESUTITES NAME OF DECEASED Middle 4. DATE Last Month Year December 61 DEATH (Type ar print) MICHELINA 19 VENTIMICITA IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthdoy) Months Days FEMALE WIDOWED DIVORCED [10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Italy Housewife TTALY 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown UNKNOWN IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address HOSPITAL RECORDS No 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL SETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED 8Y:
IMMEDIATE CAUSE (0) CORONARY THROMBOSTS minutes DUE TO Conditions, if ony, which gove rise to immediate DUE TO cause (o), stoting the under-SYSTEMIC SYPHILIS plus lying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED PERFORMED? YES NO 17 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stote) factory, street, office bldg., etc.) Hour o.m While Not while at work at work sow the deceased olive an 12 - 23 _196I , and that death occurred at 5A.M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED PHYS. DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) ILSE SPRINGFIELD STATE HOSPT. 23b. DATE THEREOF 230. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, ar county) (Stote) Baltimore. Md. New Cathedral 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

JOHN F. DENNY, Inc. 715 Light St. -30 DATE DEC 2 9'61

25g. REC'D BY REGISTRAR

arthur & Kraus

1SM 9/S9



VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| | 13815 | | CERT | IFICA | TE OF DEA | TH | | Reg. Dist. | 1.37 | 90 |
|--|---|--------------------------------|----------------------------------|--------------------|--|------------------------|---|------------------|-------------|--|
| o. COUNTY Carrol1 | | | MAR | rLAND | 2. USUAL RESIDENCE o. STATE Mar | (Where deceas | ed lived. If instituti b. COUNTY | - | before odmi | sion) |
| b. CITY OR TOWN (If RUPAL and give ne laney tow | outside corporate limi arest town) N | its, write | c. LENGTH OF STAY | IN 1b | c. CITY OR TOWN | | orote limits, write R | URAL ond give | nearest tow | n) |
| d. NAME OF HOSPITA OR INSTITUTION 31 Fred | AL (If not in hospital, querick St. | rive street o | oddress) | | d. STREET ADDRES | | Rear | | ON | SIDENCE A FARM? NOTE |
| 3. NAME OF DECEASED (Type or print) | Walter | | Middle Jacob | | ntz lost | 4. DATE OF DEATE | Mor Decemb | | Doy | Yeor 19 61 |
| Male | 6. COLOR OR RACE White | 7. MARRI | ED NEVER MARRI | | 1/28/1895 | | 9. AGE (In years last birthday) 66 yrs. | Months Da | | |
| during most of working the Blacksm1 | N (Give kind of work ing life, even if retired th |) | acksmith S | | | State or foreign | | | N OF WHA | T COUNTRY? |
| 3. FATHER'S NAME Harvey Wa | antz | | | | Flora | | | | | |
| 15. WAS DECEASED EVER (Yes. no or unknown) | IN U. S. ARMED FOR | ervice) | SOCIAL SECURITY NO 18-32-1117 | | ormant s. Mabel V | Vantz, 3 | Add 31 Freder: | rewTaney ick St. | town, | Md. |
| 422.1 Conditions, if on gave rise to in cause (a), stating t lying cause last. | he under- |)) | | | - Cordio | Vacante | or disea | al . | ONSEY AND | 3/4' |
| CATIC | ER SIGNIFICANT CON | IDITIONS <u>C</u> | ONTRIBUTING TO DE | ATH BUT N | OT RELATED TO THE T | ERMINAL DISEA | SE CONDITION GIV | EN IN PART 1(| PERF | AUTOPSY DRMED? |
| | S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DESC | RIBE HOW INJURY C | OCCURRED. | (Enter nature of injur | y in Part I ar Pa | rt II af item 1B.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Ye | ar 20d. IN While of work | JURY OCCURRED Not while of work | 20e. PLAC facto | E OF INJURY (Home, ry, street, affice bldg. | form, 20f. (Cit | ty ar town) | (Cour | nty) | (State) |
| 21. I certify the alive on ACTUAL SIGNATURE | at I attended the | decease 194 Nas | | death o | , 1957, to | ADDRESS (| m the causes of Street, city or town, | and an the | date stat | deceased ed abave. ATE SIGNED -22-4 |
| PHYSICIAN'S NAME (Type) | TAMES T | TN | 1ABSH | | W | ESTM | INSTER | m | <i>b</i> | |
| 220. BURTAL, CREMATION REMOVAL (Specify) Buria1 | 12/24/61 | | 22c. NAME OF CEM Pleasant | | crematory ey Cemetes | | ATION (City, town, sant Val | | rroll | |
| 2 FONERAL DIRECTOR'S | A. Lettle | Lit | ADDRESS tlestown, | Pa. | | REC'D BY REGIS | | STRAR'S SIGNA | | |

VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13816 CERTIFICATE OF DEATH

Reg. Dit. 3.791

| | | ACE OF DEATH | | | re deceosed lived. If institution: | Residence before admission) |
|---|----------|--|-------------------------|--|------------------------------------|------------------------------|
| | 0. (| COUNTY OAR All | MARYLAND | o. STATE | b. COUNTY | musell |
| | | | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (III ou | hide corporate limits, write RUR | Al and give nearest tawn) |
| | 10 | RURAL and give nearest town | 73 relace) | X Kural 1 | 1. he : 100 | |
| | 100 | NAME OF HOSPITAL (If not in haspital, give street ad | 12/ | d. STREET ADDRESS | v-yneovere | e. IS RESIDENCE |
| | | OR INSTITUTION | | The street reported | | ON A FARM? |
| | - | | | | | YES NO |
| | DE | CEASED 7 1/ 1/ 1/ First | 1/annv | 4 1 6 1 | 4. DATE Manth | Day Year |
| | (Ту | pe or print) CHANLES | HAKKY | Weck | DEATH WEC | 1 1/ 1961 |
| | 5. SEX | 6. COLOR OR RACE 7. MARRIE | DEVER MARRIED | 8. DATE OF BIRTH | 4 4 4 4 4 4 4 | Nonths Doys Hours Min. |
| | 7 | Tall While WIDOWED | DIVORCED [| Jan. 27, 188. | 4 77 yrs. | Months Doys Hours Min. |
| | 10a. U | SUAL OCCUPATION (Give kind of work done 10b. KI pring most of working life, even if retired) | IND OF BUSINESS OR INDU | STRY 11. 8IRTHPLACE (State a | r foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| | The | uneral attractor | Huneral | m | 20 | U.S.A. |
| | 13. FA | THER'S NAME | 1 | 14. MOTHER'S MAIDEN NA | AME | |
| | 4 | auges of Theer | de. | Rulle n | 1. ATurber | |
| | 16/W | AS DECEASED EVER IN U. S. ARMED FORCES? 16. SC | OCIAL SECURITY NO. | NFORMANT | Address | 1 1 |
| 4 | Ares, no | o. or unknown) (If yes, give war or dates of service) 2/2 | 7-14-7698ABM | Willard H. | Tilear . Ofen | beingle Tell |
| | 118 | B. CAUSE OF DEATH [Enter only one couse per line | | 1 | and you | INTERVAL BETWEEN |
| | 13 | PART I. DEATH WAS CAUSED BY: | 1 Mars | 1 Carren | Mr. 0 | ONSET AND DEATH |
| | | IMMEDIATE CAUSE (a) | Lew Coras | 1 Carried | - cognesses | 15.54 |
| | | 4201 DUE TO | 17 | Luk di | B. On 00. | 70 |
| | | Conditions, if ony, which gove rise to immediate | resident | , nem our , | - nevince | 10 |
| | C | couse (a), stating the under- | . 0 .1. 11. | 1. Censury | | 1961 |
| _ | 7 = | ying cause lost. (c) (lend | ratific - [N | A | | |
| | 5 | PART II. OTHER SIGNIFICANT CONDITIONS CO | NIKIBU NNG TO DEATH BUT | NOT RELATED TO THE TERMIN | IAL DISEASE CONDITION GIVEN | PERFORMED? |
| | FICATI | | | | | YES NO |
| | E 0 | R CONTRIBUTING CAUSE OF DEATH | 18E HOW INJURY OCCURRE | D. (Enter noture of injury in Po | ort I or Port II of item 18.) | |
| | - 1 | F EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| | | c. TIME OF INJURY Manth, Day, Year 20d. INJ Hour a. m. While | Not while 20e. PL | ACE OF INJURY (Hame, form, ctory, street, office bldg., etc.) | 20f. (City or town) | (County) (Stote) |
| | MEDI | p. m. 19 at work | | | | |
| П | 2 | 1. I certify that/lattended, the deceased | from 1912 | 19 | 96/ 19 th | of I lost saw the deceased |
| | a | live on He Leve 6/ 19 | and that death | occurred at 8:00 0 :1 | M. from the couses and | on the dote stated above. |
| | | A 0 7 7 | | | DDRESS (Street, city or town, sto | |
| | A | GNATURE ACCUPATION & A | all' | M.D. | Marrelle, | me 13 blice |
| | | | 1 / 1 | - 1 | | - 14. |
| | | AME (Type) HOWARD E. | HALL | 34/ | RESVILLE | -, MD |
| | | URIAL, CREMATION, 22h. DATE THEREOF | 22c. NAMBOF CEMETERY O | R CREMATORY | 22d. LOCATION (City, town, or | county) (State) |
| | 7 | EMOVAL (Specify) 12-14-6/ | Afrinasu | NO I | Olykisidle 1 | anoll & my |
| | 23. FU | NUMBER OF STATE | APORESS A Una | / 24a. REC'D | BY REGISTRAR 246. REGISTE | AR'S SIGNATURE |
| | 15 | Marcht Saight 1 | Hyklesielle, | MUN DATE EC | 19'61 Carrie | 1 S. Times |
| - | 1 / 8 | 110000 | 1 | 1 - 4 | | |

